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Non-Formal Education

My Therapist Weighs 900 lbs.

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CHILDREN OF ALCOHOLICS

What We Should Know
How We Can Help

HE 23.12:

January-February 1986
Volume 15 Number 1

children today

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Cover Design: Jacque Roland

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FYI / Worth Noting

Information on Alcoholism...The National Clearinghouse for Alcohol Information has prepared information kits to respond to requests received following the broadcast on January 6 of Shattered Spirits, the ABC television film that depicted the effects of a father's alcoholism on his family. Separate kits are available with materials targeted to children, parents, educators, community group leaders, counselors and other treatment professionals. Kits may be obtained free from the National Clearinghouse for Alcohol Information, P.O. Box 2345, Rockville, Md. 20852 (301) 468-2600. Please designate type of kit desired when ordering.

Interagency Panel Meets...Some 150 researchers from federal agencies and universities in the Washington, D.C. area attended a conference in December in celebration of International Youth Year. Sponsored by the Interagency Panel on Research and Development on Children and Adolescents, the 2-day conference--"Youth and America's Future"--featured presentations on new research findings and discussion of informational needs regarding adolescents.

In a wide-ranging and thought-provoking address, Harold L. Hodgkinson, Ph.D., former director of the National Institute on Education and currently scholar-in-residence, American Council on Education, outlined changes in population groupings that are affecting the educational system--which he views as a single entity, from nursery schools through post-graduate institutions, through which people move. In addition to hearing other presentations by Joseph L. Coates of J.L. Coates Associates and John Hill, Ph.D. of Virginia Commonwealth University, conferees attended workshops covering such topics as physical and mental health, substance abuse, juvenile justice, adolescent pregnancy and youth and the military. A video tape of the conference will be produced by the new ACYF-funded National Resource Center for Youth Services (see page 2).

Children's Bureau Funds National Resource Centers

The Children's Bureau, ACYF, has awarded grants to create six National Resource Centers for Child Welfare Services. The Resource Centers, which are intended to be a comprehensive and coordinated effort to improve child welfare services throughout the nation, will be working in the following program areas: family home-based prevention services, foster care, legal consultation in child welfare, program management and administration, youth services, and special needs adoption. The six Centers are:

National Resource Center for Family Based Services
School of Social Work
University of Iowa
N-240A Oakdale Hall
Iowa City, IA 52242
Janet R. Hutchinson, Director

National Resource Center for Foster and Residential Care
Child Welfare Institute
P.O. Box 77364, Station C
Atlanta, GA 30357
Ronald K. Green, Director

National Legal Resource Center on Child Welfare Programs
American Bar Association
1880 M St., N.W., Suite S-200
Washington, DC 20036
Robert Horowitz, Director

National Resource Center for Child Welfare Program Management and Administration
Human Services Development Institute
University of Southern Maine
246 Deering Ave.
Portland, ME 04102
Helaine Hornby, Manager

National Resource Center for Youth Services
University of Oklahoma
440 S. Houston, Suite 751
Tulsa, OK 74127
James M. Walker, Director

National Resource Center for Special Needs Adoption
Spaulding for Children
3660 Waltrous Rd.
P.O. Box 337
Chelsea, MI 48118
Judith K. McKenzie, Director

Project directors for the Centers met in Washington, D.C. in November to present their workplans for the first year. ACYF Commissioner Dodie Livingston reemphasized the great need for coordinated services in the child welfare field. She expects the Centers to implement their workplans as approved for funding and to provide technical assistance to child welfare agencies and the public, reach out to the communities for whom they are providing support, and become self-sufficient institutions in three years.

The establishment of the National Resource Centers represents a departure from the past. In keeping with the Office of Human Development Services' entrepreneurial emphasis, cost benefit and effectiveness will be critical measures of success. The Centers will be expected to seek a great deal of their funding from sources other than the federal account. The project's short- and long-term success will depend on how responsive the Centers are to the needs of the field and how effective they are in locating other funds. Particularly, state agencies and community programs are expected to bear part of the cost for the consultation and services they require.

Three years from now, when the federal funding ends, the Centers are expected to survive on their own because they are needed, relevant and helpful to agencies and professionals in the child welfare field.

The Children's Bureau awarded only six of the original nine grants it had announced in the *Federal Register*. However, a new announcement was published in the *Register* on Nov. 5, 1985, asking for new proposals to be submitted for resource centers in developmental disabilities, child abuse and child sexual abuse.

Garbarino Receives Kemp Award

James Garbarino, Ph.D., President of the Erikson Institute for Advanced Study in Child Development, has been selected as the first recipient of the C. Henry Kempe Award for outstanding professional accomplishment in the field of child abuse and neglect prevention.

The award, presented at the National Conference on Child Abuse and Neglect last November, is named after Dr. C. Henry Kempe, the pediatrician who pioneered the concept of the "battered child syndrome" in the 1960s. Established to honor the memory of Dr. Kempe, who died in 1984, the award car-

ries with it a $5,000 grant to the Erikson Institute to promote child abuse prevention activities.

Garbarino is the author or editor of five books and numerous articles and lectures on child abuse and neglect, and he has served as a consultant on the topic to organizations throughout North America and abroad. As a result of the award, he will direct and teach a special course for professionals at the Institute in June. Guest lecturers for the course, which will present advanced instruction in the theory and practice of child maltreatment, include Anne Cohn, Executive Director of the National Committee for Prevention of Child Abuse, Jon Conte of the University of Chicago, and Judith Musick, Executive Director of the Ounce of Prevention Fund.

Further information on the course may be obtained from the Registrar, Erikson Institute, 25 W. Chicago Ave., Chicago, Ill. 60610.

Radiation and Scoliosis

The growing emphasis on school screening for scoliosis has probably led to an increase in the number of x-ray examinations of the spine—which has led the Food and Drug Administration (FDA) to launch a campaign alerting parents to the risks of radiation exposure during scoliosis examinations and methods of minimizing the exposure during such exams.

Scoliosis, which generally appears between the ages of 10 and 15 and affects five to 10 percent of all adolescents to some degree, is defined as an appreciable lateral curvature in the normally straight line of the spine. While very mild scoliosis occurs at the same rate in both sexes, adolescent girls are seven to nine times more likely to develop clinically detectable spinal curvature that requires treatment or, at least, follow up.

More than half of the states conduct physical (non-radiographic)

scoliosis screening programs for children in some or all of their school jurisdictions. After an initial physical exam, suspected cases are generally referred to a health practitioner to confirm the diagnosis and to evaluate the condition. Many children with mild curvatures who do not require treatment are periodically monitored using x-rays to ensure that curvatures are not increasing. Scoliosis patients are usually examined at least once a year and some as often as every three or six months. One or more x-rays may be needed each time.

The FDA notes that health professionals are becoming increasingly aware of the need to reduce radiation exposure during these x-ray examinations, especially for girls. Studies indicate that developing breast tissue is particularly sensitive to the effects of radiation and that repeated exposure of the breast during adolescence can increase a woman's risk of breast cancer in later life.

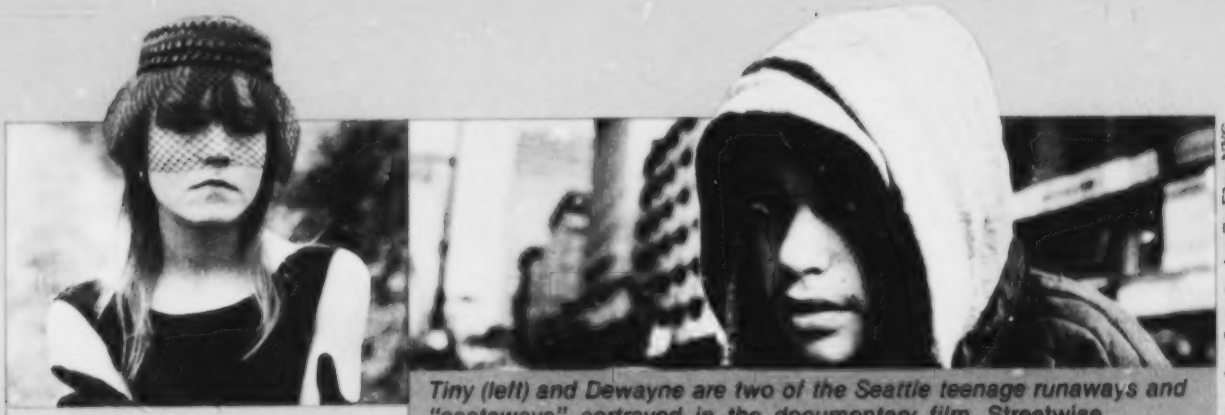
However, the FDA points out that there are ways to significantly reduce radiation exposure of the breast without compromising the quality of the x-ray. These include the use of compensating filters, fast screen/film combinations and breast shields:

- A compensating filter, made of aluminum, stainless steel or transparent lead, can be fitted onto the x-ray tube using magnets, special holders or slots. The filter absorbs much of the x-ray beam directed to the chest area, improves the image and reduces breast tissue exposure by two to five times.
- The faster or more sensitive the film and screen used, the lower the radiation exposure of the patient. A combination called "rare-earth" is frequently used in scoliosis x-rays because it requires less radiation exposure without significantly affecting image quality. This technique reduces breast tissue exposure from two to six times.
- Two types of breast shields can be used. Contact shields are vests or stole-like garments with lead inserts that are worn by the patient to cover the breast area. Shadow shields are adjustable metal plates attached to the x-ray machine that cast a shadow over the breast area. Shielding reduces radiation exposure to the breast tissue by three to 10 times. Another method is to turn the patient around so that she faces away from the x-ray machine. The body then acts as a shield for the breast tissue.

Each of these techniques by itself can lower radiation exposure markedly and, when they are used together, the exposure reduction is even greater.

The FDA urges parents and other caregivers to ask their doctor about employing any or all of these techniques when their child is x-rayed.

More detailed information on reducing radiation exposure may be found in *Reducing Patient Exposure During Scoliosis Radiography*, a pamphlet available from FDA, HFZ-240, Rockville, Md. 20857.



Tiny (left) and Dewayne are two of the Seattle teenage runaways and "castaways" portrayed in the documentary film, **Streetwise.**

Photos from Streetwise, Angelika Films, NYC

FYI /Reports

Runaway Youth: A Profile

A 1983 national survey completed by the Department of Health and Human Services estimates that 1.3 to 1.5 million children and youth run away from home each year. Some 36 percent run away because of physical or sexual abuse, 44 percent from other severe long-term problems, and 20 percent from temporary or less severe crises. About 25 percent are hard core "street kids" in serious trouble, of which three quarters engage in some type of criminal activity and half in prostitution, specifically. In 1976, shelters funded under the federal Runaway and Homeless Youth Act served 15,000 young people. In 1984, the shelters served 60,500 runaways as well as an additional 245,000 youths on a one-time, drop-in basis.

These are among the statistics reported in *To Whom Do They Belong? A Profile of America's Runaway and Homeless Youth and the Programs That Help Them,* which was prepared by the National Network of Runaway and Youth Services, Inc., a private, nonprofit youth advocacy membership organization of more than 500 community-based shelter programs and other agencies that serve runaway, homeless and other troubled youth. The report was funded by the Network's National Fund for Runaway Children, which pools contributions from individuals, foundations and corporations and awards grants to runaway and homeless youth programs.

The report summarizes findings and recommendations of a needs assessment survey conducted by the Network based on data from 210 youth service agencies across the country, including shelters, hotlines and foster care programs. The report raises the following issues for consideration by service providers and policymakers: How many youths are coming to shelters and what kinds of problems do they have? Do shelters help these troubled young people and, when possible, their families? What additional services are needed for these youths to redirect their lives toward self-sufficiency and law-abiding behavior and away from future dependency on public assistance?

According to the study, there is no "typical" runaway or homeless youth. The runaway and homeless population ranges in age from 12 to 18 and consists of male, female, white, black, Hispanic, Asian, urban and rural youth from every socioeconomic class and state in the country. Increasingly, these children are "pushouts" or "throwaways" who have been abandoned by seemingly uncaring families, schools, communities, child welfare and mental health systems. They are under-educated and become involved with drug dealing, prostitution or child pornography to survive.

Social service professionals responding to the survey believe that a high percentage of youth run away because their families have become "dysfunctional." Care providers conclude that the root cause of runaway behavior and homeless youth is disintegration of the family structure through separation, divorce, poverty and high mobility.

Accessible shelter and hotline services, available 24 hours, seven days a week, are hallmarks of the national network of runaway youth shelters. These services are supplemented by crisis and long-term individual and family counseling; outreach; advocacy; referrals for medical, legal or mental health assistance; and follow-up services. Counseling, health care, remedial education, and independent living programs—involving housing, life skills, money management and pre-employment training—have produced the most effective results.

While primary objectives of the shelters include reuniting youths with their families and encouraging resolution of family problems, the study indicates that only 50 percent of runaway and homeless youth have a realistic prospect for family reunification or long-term foster care placements. Less than one in 10 are considered ready for emancipation or independent living.

Survey respondents cited the need for more staff, increased staff training and higher salaries, and indicated a need for improved preventive and aftercare programs and greater access to specialized

mental health services for young people and their families. June Bucy, executive director of the National Network, stresses the necessity for more resources and complementary services to help homeless and runaway youth programs cope effectively with the increasingly severe, diverse youth and family problems they face.

Bucy concludes: "Survey results reveal that 57 percent of the troubled youth using shelter services are reunited with their families or positively placed in a safe living environment. This figure demonstrates that shelter programs are an effective way of preventing a future of welfare dependency, criminal activity, adult homelessness, and other personal and family tragedies that result in serious drains on taxpayers and the economy. As policymakers and social science researchers examine the relationship between child abuse, runaway behavior, crime, and unemployment, it is important to note that a nationwide system of community based runaway and homeless youth services exists which offers a cost-effective alternative to a future generation of adults and families who cannot contribute to our nation's economic health and well-being."

Copies of the 37-page report—which includes a bibliography featuring books, magazines and federal government studies that focus on runaway and homeless youth—are $4 each from the National Network of Runaway and Youth Services, 905 6th St. S.W., Washington, D.C. 20024.

Prisons and Kids

Information on programs for prison inmates and their children, designed for correctional administrators, legislators and advocates concerned about practical, legal and ethical issues is presented in *Prisons and Kids: Programs for Inmate Parents*,published by the American Correctional Association (ACA).

The 49-page monograph—written by James Boudouris, Ph.D., and based on an earlier report for the Iowa Department of Corrections—summarizes results of a survey of programs in 57 correctional institutions nationwide, including prison nurseries and day care centers. Information was obtained from respondents in 55 state institutions and two federal institutions, representing a total of 15,337 incarcerated women. The study examines visitation policies and procedures, family and conjugal visits, community facilities, parenting classes, furloughs, support services for inmates and penal colonies.

Boudouris explores such issues as the following: Should infants and young children live in correctional institutions with their incarcerated mothers? Do bonding and parenting play a role in rehabilitation? What are the effects of an institutional environment on children? What can correctional institutions realistically provide for inmates and their families?

The author details the experiences institutions have had with their programs and attempts to discover reasons for the success or failure of various efforts, citing arguments of both proponents and opponents. Findings from a review of the literature are featured, including works in sociology, psychology, psychiatry, social work, law, pediatrics and corrections. Legal issues and concerns of child development specialists are discussed, and appendices provide an extensive bibliography, a list of sources, and an easy-to-read table that summarizes programs state-by-state.

Boudouris believes that for humanitarian and moral reasons more can be done for inmates' children, and asserts that the extent to which infants and young children can be cared for at correctional institutions must be decided on the basis of the amount of funds a state is willing to commit to such programs, as well as individual institutional circumstances. He points out that in some cases a child's best option may be to remain with the mother in a correctional institution, particularly when placement with other family members is not possible. Reasons for abandoning prison nurseries, the author explains, seem to be rooted in administrative or political policies and are not related to the programs' benefits for children, inmates or the institution.

Boudouris concludes: "Traditional ideological conflicts among advocates of security/control, punishment, revenge, retribution, deterrence, reintegration, or rehabilitation have negative consequences for the inmate and his or her family. Resolution of these conflicts is not likely to come from rhetoric but from the willingness of decision makers and policy makers to be more open-minded and supportive of scientific evaluation of their policies and programs."

Copies of *Prisons and Kids* are $17.95 each and can be ordered from the American Correctional Association, 4321 Hartwick Rd., Suite L-208, College Park, Md. 20740.

Business and Schools

This year alone, more than 700,000 young people will drop out of school, and well over 25 percent of the nation's high school students never graduate. Many who graduate and go on to higher education need remedial reading and writing courses, which about two-thirds of U.S. colleges now provide. Nearly 13 percent of all 17-year-olds still in school are functionally illiterate and 44 percent are only marginally literate. An estimated 60 percent of dropouts are functionally illiterate.

These are some findings from a report, *Investing in Our Children: Business and the Public Schools*, published by the Research and Policy Committee of the Committee for Economic Development (CED). Founded in 1942, CED is a nonprofit, nonpartisan research and education organization—composed of business executives and educators and funded by private contributions from business, industry, foundations and individuals—which seeks solutions to pressing social and economic issues that most affect the long-term health of the nation's economy. CED's 225 trustees, most of whom are corporate or university presidents, study public policy issues, formulate and vote on solutions, and promote their adoption by business and government.

A million-dollar, 3-year research effort, *Investing in Our Children* was financed in part by a coalition of 16 private and corporate foundations and developed by a panel of business and education leaders headed by Owen B. Butler, chairman of the board of The Procter & Gamble Company. The project was directed by Denis Doyle, resident fellow in education, and Marsha Levine, education consultant, both of the American Enterprise Institute for Public Policy Research.

Results of a survey commissioned by CED of 400 large and 6,000 small businesses and 500 2- and 4-year colleges indicate that the schools are not adequately preparing students to succeed either in the job market or in college. Improving the quality of public education, the report argues, is "the most important investment this nation can make. Without a skilled adaptable and knowledgeable work force, neither industry nor government can work efficiently or productively."

The report outlines a strategy for improving the nation's investment in public education by upgrading curriculum and standards, preventing educational failure, bolstering the professionalism of teachers, reorganizing vocational education, redeploying educational dollars, and building strong partnerships between business and public schools. Local and national business leaders and policymakers are urged to unite with parents, educators and boards of education to support lasting reform, and far-reaching changes are advocated where learning takes place—in the individual school, in the classroom, and in the interaction between teacher and student. Challenging the wisdom of reform proposals that rely on "top-down" prescriptions for government, the panel recommends giving more decision-making authority to those on the educational firing line—principals, teachers and local boards of education.

Citing the need to prevent educational failure rather than relying on remedial efforts, the report emphasizes that more resources should be devoted to the early stages of educational development—particularly preschool programs for disadvantaged children and the elementary grades.

The report calls for "nothing less than a revolution in the role of the teacher and the management of the schools" and offers a strategy for upgrading recruitment, training, incentives and monetary compensation for teachers. It points out that "business has much to gain from improvements in the quality of the schools, and it has a responsibility for helping to support and maintain that quality." Although American business has a long tradition of involvement in the schools, "much of this activity has been on a case-by-case, project-by-project basis rather than a systematic effort to make the most of business' resources."

Strategies that business can take to improve public education include assistance in developing curriculum, cooperation with local school districts to define goals based on mutual needs, engaging in local business-school partnership programs that utilize proven techniques, and encouraging employees to serve on local school boards and providing flexibility in working hours to make this possible. The report also recommends that business support initiatives for increased public school funding, provide loaned executives to assist in training concerning modern management techniques, and offer its expertise in public relations or finance.

Copies of the CED report are $11.50 each for hardcover and $9.50 each for paperback (plus a 10 percent charge for postage and handling costs), and can be ordered from the Research and Policy Committee, Committee for Economic Development, 477 Madison Ave., New York, N.Y. 10022.

FYI /Resources

Lowe's Syndrome Association

In the past, parents of children with Lowe's syndrome—a rare genetic oculo-cerebro-renal (eye-brain-kidney) syndrome that affects males and causes multiple handicaps and serious medical problems—often felt isolated and had nowhere to turn for information and support. Now they can seek help from the Lowe's Syndrome Association (LSA), an international, voluntary, nonprofit organization formed by parents in 1983 to foster communication among families affected by Lowe's syndrome.

Composed of parents, medical and educational professionals, and others interested in this condition, the group strives to provide information, promote a better understanding of Lowe's syndrome and encourage and assist medical

research. *On the Beam*, the LSA newsletter for members published three times a year, features letters from parents and photographs of their children, articles by medical and educational researchers and other information about the disorder.

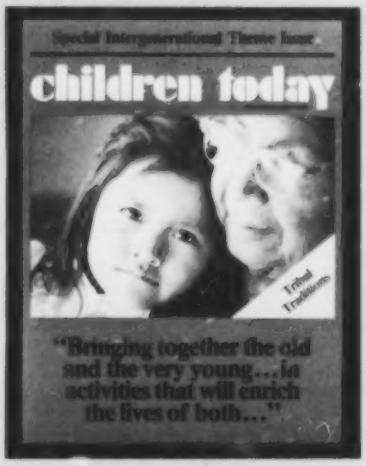
Lowe's syndrome is believed to be caused by an inborn error of metabolism carried on the genes of the "X" chromosome. Although only males are affected, female carriers may transmit the gene to their sons. While there is no cure, there are effective treatments and medications for several symptoms.

Symptoms of Lowe's syndrome may include congenital cataracts; glaucoma (in about half the cases); intellectual impairment, ranging from low-normal to severe; poor muscle tone; renal tubular dysfunction (a kidney disorder resulting in abnormal loss of nutrients in the urine); acidosis; a tendency to develop rickets and other bone problems; and seizures (in some cases).

Although boys with Lowe's syndrome are often developmentally delayed, they can learn to be productive students, workers and participating members of society with good medical care and early education and training. In their early months and years, they may need physical, occupational and vision therapies, which are provided in infant stimulation programs or preschool programs for handicapped children. Most children with Lowe's syndrome live at home and participate in family and community activities, while some adults live in group homes and have jobs in sheltered workshops. Those with the condition have a longer life expectancy today than in the past because of a greater understanding of Lowe's syndrome and its treatment.

Further information on the organization and membership categories may be obtained from the Lowe's Syndrome Association, 222 Lincoln St., West Lafayette, Ind. 47906.

Letters



Intergenerational Issue

I was delighted to see the special intergenerational theme issue of CHILDREN TODAY (September-October 1985). It was well done, readable and extremely interesting.

I would, however, like to alert you to a very special type of intergenerational programming that was not included in the issue: the combined care of the young child and the frail elderly at the elder care setting. The fascinating article on "Transmitting Tribal Traditions" comes close, but it is rightly focused on the ethnic link between participating children and elders. In my recently completed study, intergenerational combined care has proven feasible at 51 sites (nursing homes, adult day care centers, housing, etc.) throughout the nation. Combined care works beautifully without an ethnic match-up.

Carol R. Hegeman
Principal Investigator
Child Care in Long Term Care Settings
Foundation for Long Term Care, Inc.
Albany, New York

Editor's note: A manual based on Carol Hegeman's research has recently been published. Child Care in Long Term Care Settings, *funded by the Retirement Research Foundation, provides detailed information on the benefits of such collaborative programs and includes six case studies of different types of intergenerational programs. Copies of the manual are available at $14.50 each from FLTC, 194 Washington, Ave., Albany, N.Y. 12210.*

Congratulations on the special issue of CHILDREN TODAY devoted to intergenerational programming. I am sure the wealth of information provided will be a stimulus for increased activities of this nature.

John Radig, Rosalie Minkin and I, as New Jersey's "graduates" of the Wingspread Conference, have convened a group of interested persons who have decided to call themselves The New Jersey Coalition for Intergenerational Programs. One of the objectives of the group is to make presentations on intergenerational programming at annual conferences of appropriate statewide organizations. Thus far, presentations are scheduled for March 21 at the N.J. Chapter of the National Association of Social Workers' Social Worker's Day and for May 8 at the Spring Conference of the N.J. Association for Lifelong Learning.

We plan to distribute pertinent materials to workshop participants and would be delighted if the September-October 1985 issue of CHILDREN TODAY could be included. I would be most appreciative if 100 copies of this special issue could be provided for distribution at these workshops and for sharing with the area agencies here in New Jersey.

Lois Stewart
Division of Aging
New Jersey State Department of Community Affairs
Trenton, New Jersey

CHILDREN OF ALCOHOLICS

What We Should Know; How We Can Help

by Charles D. Weddle and Phillip M. Wishon

Alcoholism is a disease of epidemic proportions in the United States. It is estimated that there are 9.3 to 10 million alcoholics,[1] and many professionals believe the figure to be more like 20 million. While alcoholism is generally recognized as a disease, it is not as widely recognized as a *family* disease, with devastating consequences reaching far beyond the alcoholic to spouses, children and others. Estimates indicate that there are some 28 million children of alcoholics in this country, seven million of whom are under age 18.[2] The purposes of this article are to establish the significance of the problem, identify characteristics among affected young children and discuss some of the implications for professionals concerned with the welfare of young children.

Alcoholism As A Family Disease

There is no question that the disease of alcoholism has debilitating effects on the afflicted—the alcoholic. The type and degree of such problems vary from alcoholic to alcoholic depending on a multitude of factors, such as the stage to which the disease has progressed. Examples include loss of job, alienation of friends, abandonment by family, imprisonment, institutionalization and death. Alcoholism is a serious social problem as well. According to Milam and Ketcham, alcohol is involved in up to 60 percent of known child abuse cases and most instances of battering, and alcohol use is evident in up to 40 percent of all assaults, 39 percent of rapes and 64 percent of homicides committed. Thirty-five to 64 percent of all fatal automobile accidents involve drivers who had been drinking.[3] In addition, alcoholism is a major cause of death in the United States.[4] These rather direct results of problem drinking are staggering. However, other effects of the disease on those close to the alcoholic, particularly children, are more subtle and tend to go unnoticed and, therefore, untreated.

As a class of individuals requiring specific intervention, children of alcoholics have been, until recently, virtually ignored. There are several reasons as to why this has been so. First, most professional intervention is aimed at the alcoholic, with little attention directed toward others whose lives are touched by the disease. Second, there has been a general lack of public understanding about the wide-ranging impact of the disease of alcoholism.

Finally, living in an alcoholic home still is not something that children openly share and, in fact, try to hide. In addition, since many young children have no basis of comparison between their home life and that of other children, they often have the deluded perception that their home life is "normal." As a result, it is extremely difficult to detect the problems of young children of alcoholics in all but the most obvious situations.

Characteristics of Children

Most children from alcoholic families are identified based upon the demonstration of overt behaviors or traits and treated for symptoms rather than the cause. In order for early childhood professionals to better serve young children of alcoholics, we must first develop an understanding of some of the characteristics exhibited by these children.

Of course, not all children exhibiting aberrant behavior are from alcoholic homes. As with most behaviors, one cannot assume with any degree of certainty a direct cause-effect relationship between living in an alcoholic home and the characteristics described here. The presence of these characteristics should serve to alert us that alcoholism *may* be a source of the

Charles D. Weddle, Ed.D., is Assistant Professor, College of Education, University of Hawaii, Honolulu. Phillip M. Wishon is Associate Professor, College of Education, University of Northern Colorado, Greeley.

Design Jacque Roland

observed deviance. Obviously, alcoholism is a sensitive issue and must be approached as such. The problems associated with this family disease, and the potential impact of these problems upon the nation's young, are acute enough to necessitate careful consideration. We emphasize that our purpose here is to provide insights helpful in working with *young children* of alcoholics—not the alcoholic himself or herself.

Developmental Considerations

The characteristics of children of alcoholics, as identified by clinicians, fall into three broad categories: general, physical and emotional characteristics. These characteristics may be present in isolation or in combination, and may occur in varying degrees.

General Characteristics

Clinicians have identified many general characteristics as being associated with being reared in an alcoholic environment. Drew has found that such children assume certain roles related to their ordinal position within the family.[5] For example, the youngest child often tends to be a performer or clown, while the oldest child frequently takes on adult-like roles and responsibilities earlier than his age-mates. The middle child often seems to get "lost in the shuffle." Of course, birth order may not be the only predictor of these roles.

Children of alcoholics may assume one of four roles identified by Wegscheider.[6] The *hero* tends to be the oldest and exhibits very mature behavior. The *scapegoat* takes unwarranted blame for family problems and disturbances. The *lost child* tends to be the ignored middle child, while the *mascot*, often the youngest child, is protected and isolated from family problems. Children assume these roles as a result of parental inconsistency. In the alcoholic home, fluctuations between rigidity and the absence of controls are commonplace, and this type of atmosphere may leave the child confused and bewildered.

In addition to the roles that they assume, the following characteristics are often found among children of alcoholics by those who treat them. These children may:

- become isolated and afraid of people, particularly authority figures.
- become approval seekers, losing their identities in the process.

- be frightened by angry people and/or personal criticism.
- live life from the viewpoint of helping others and seeking "victims" for this purpose.
- have an overdeveloped sense of responsibility.
- experience guilt feelings when standing up for themselves.
- confuse love with pity.
- bury feelings.
- judge themselves harshly due to poor self-esteem.
- be terrified at the thought of abandonment.
- be reactors rather than actors.
- eventually become alcoholics, marry them, or both—or find another compulsive personality with whom to share their lives.

The following sections expand upon some of the factors contributing to the development of these characteristics.

Physical Considerations

There are serious threats to normal physical development of the fetus of an alcoholic mother. Although no one knows exactly how much alcohol it takes to cause alcohol-related birth defects, it is known that as few as two drinks per day increase the chances for children to be born with Fetal Alcohol Syndrome.[7] The potential for physical anomalies associated with Fetal Alcohol Syndrome include higher rates of infant mortality; prematurity; poor motor development; disfigurement; and irreversible, immature physical development. In addition, Fetal Alcohol Syndrome is the third largest cause of mental retardation.[8]

Physical problems may also occur when the father is the alcoholic, although the effects of paternal alcoholism on the developing fetus may be indirect and more subtle. It is known, for example, that the emotional state of the mother has a direct impact upon the physical development of the unborn. Mothers living with alcoholic partners may be under a great deal of stress. The degree of maternal anxiety is directly affected by the stage of her partner's alcoholism during pregnancy.[9] If the expectant mother is concerned about his fitness as a provider or father, or is fearful for her or the child's welfare, her anxiety level may be quite high and influence the quality of the pregnancy. The subsequent reduction in the viability of the pregnancy may have deleterious effects upon the fetus' physical development.

Alcoholism also has an effect on the child's experiences during infancy and childhood. Chief among these are those caused by child abuse. Furthermore, children reared in alcoholic home environments are often neglected, with their needs for nourishment and proper care left unattended.[10]

Emotional Considerations

When young children are raised in the volatile, repressive or inconsistent atmosphere that typifies many alcoholic homes, healthy emotional development is often impeded. This is largely due to the fact that one of the most basic of human needs, the need for security, goes unsatisfied. This can occur even when the parents desire to be nurturant and caring. Some alcoholics, even those who are well-intentioned, are too concerned with alcohol to provide the sort of feedback necessary for children to develop a sense of security. An inadequate sense of security, in turn, diminishes the quality of the child's interactions and personal relationships with others.

Although the alcoholic parent often wants to provide a consistent atmosphere that would facilitate normal emotional development, he or she may simply be unable to do so. The nondrinking parent may be so caught up in the problems caused by the spouse's alcoholism that there is little time or energy left to devote to fostering the child's growth and development. The host of issues that may confront the non-alcoholic parent on a regular basis include assuming roles that should be under-

taken by the alcoholic, covering up and making excuses for the alcoholic, and dealing with his or her erratic behaviors. In a survival sense, these problems may often take precedence over the child's needs.

Neglect of the child's needs may not be intentional. It is simply the nature of the disease as it progresses to consume vast amounts of time and energy, leaving little for other matters. Alcohol and the alcoholic's behavior often become the central focus of attention, thus diverting attention from the child. Those who treat young children of alcoholics find that their emotional development is often quite poor as they are reduced to struggle to maintain themselves in an environment void of nurturance.[11]

Emotional Defensiveness

Papalia and Olds indicate that children of alcoholics typically employ various defense mechanisms to escape, rather than confront, their feelings.[12] These include:

- regression or slipping back to a more secure time. This is particularly true during times of crisis—since the present is too painful to face, a more comfortable time is sought.
- repression or simply ignoring the security-threatening situation.
- sublimation or focusing energy on a sanctioned or approved activity. The young child may spend inordinate amounts of time on some singular activity to escape the chaotic atmosphere of the home.
- projection or inappropriately placing blame for certain behaviors on others.

While most individuals employ these defense mechanisms to some extent, children of alcoholics seem to rely on them heavily. Dependency on the use of such defenses carries over into adulthood in many cases and further restricts the development of an accurate sense of self.

Personality Development

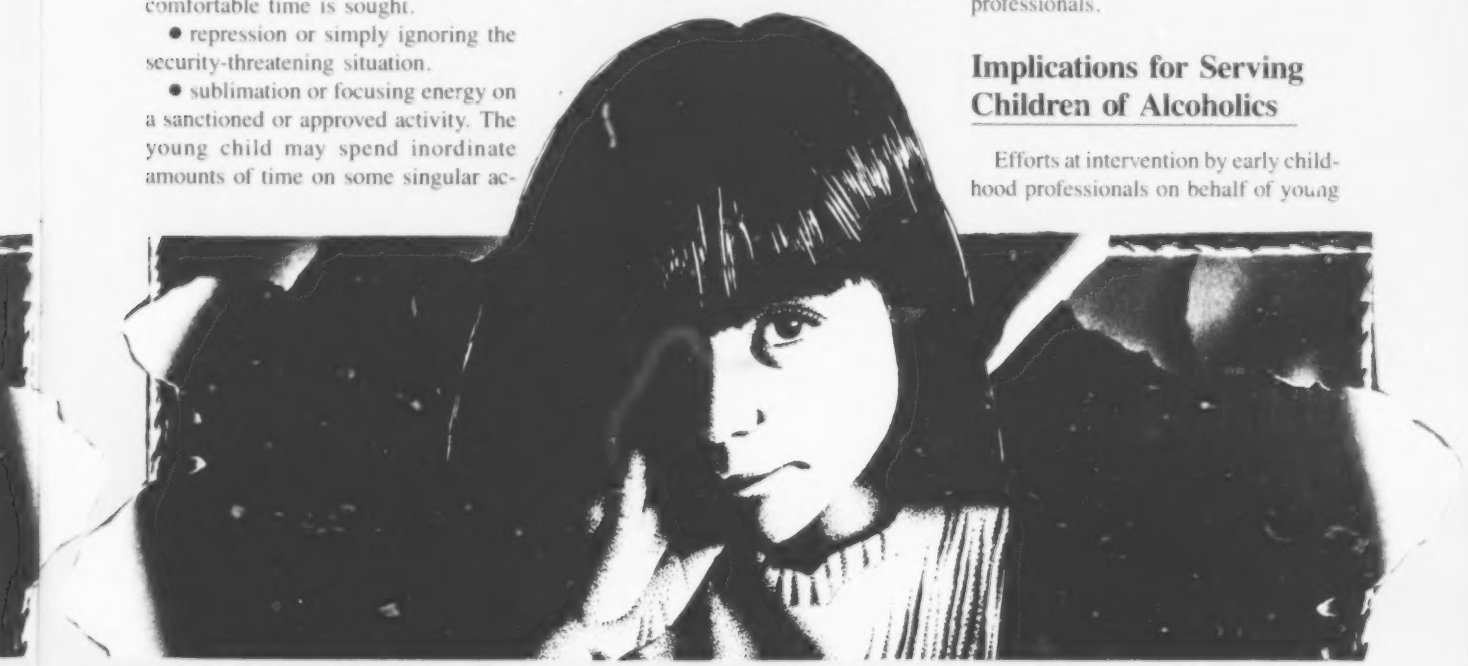
The development of personality is related to emotional development. Ackerman discusses personality development among children of alcoholics in terms of Erikson's stages of psychosocial development and offers the following observations:[13]

- During infancy the development of a sense of trust may be seriously threatened due to the severe strains on the parents' marital relationship. Because of the young child's immature language development, concerns cannot be communicated and frequently go undetected.
- The toddler's development of autonomy may be hampered due to overprotection and restrictiveness by an unwitting parent seeking to shield the child from the negative home environment.
- Due to the self-centeredness of the alcoholic, the child's natural inclination toward inquisitiveness and innovation may be stymied. This restricts the child's ability to take initiative appropriately during the preschool years.
- The young child may develop a sense of inferiority since his or her accomplishments and achievements often go unnoticed in the home.

While the problems encountered by young children of alcoholics may stem from the home environment, it is important that early childhood professionals be prepared to nurture these children and to intervene when appropriate. Often the day care, preschool or public school environment is the only source of security and stability for them. Providing experiences that enhance the self-esteem of all young children should be a goal of child care professionals.

Implications for Serving Children of Alcoholics

Efforts at intervention by early childhood professionals on behalf of young



children of alcoholics should be directed toward the children themselves. It is beyond the scope of most professional child caregivers to attempt to treat the alcoholic and the complex disease of alcoholism. However, there are several ways in which professionals involved with young children can be of assistance:

- We should make every effort to become more educated and consequently more understanding about the disease of alcoholism and its intrafamilial effects. Those wishing to learn more about the problem and its effects on children can do so through a variety of sources, such as the references and resources that accompany this article.
- In cooperation with other agencies, we could develop age-appropriate alcohol awareness programs aimed at educating young children about alcohol abuse.
- We must provide referrals to other agencies in cases where the child might benefit from such referrals. If child abuse is suspected the child must be assisted; if counseling is needed this must be recommended.

The disease of alcoholism has far-reaching effects on the children of our society. It is imperative that child care professionals become familiar with the problem and seek to serve those children affected. It is not a problem that will disappear, and it cannot be ignored. ■

[1]National Institute of Alcohol Abuse and Alcoholism, *Facts About Alcohol and Alcoholism*, Rockville, Md., NIAAA, 1980.

[2]*Report of the Conference on Research Needs and Opportunities for Children of Alcoholics*, New York, Children of Alcoholics Foundation, Inc., 1984.

[3]J.R. Milam and K. Ketcham, *Under the Influence*, New York, Bantam Books, Inc., 1983.

[4]National Institute on Alcohol Abuse and Alcoholism, *4th Report to Congress on Alcohol and Health*, Rockville, Md., NIAAA, 1981.

[5]T.R. Drew, *Getting Them Sober*, Vol. 2., South Plainfield, N.J., Bridge Publishing, Inc., 1983.

[6]S. Wegscheider, "Children of Alcoholics Caught in Family Trap," *Focus on Alcohol and Drug Issues 2*, May-June, 1979.

[7]A.P. Streissguth, S. Landesman-Dwyer, J.C. Martin and D.W. Smith, "Teratogenic Effects of Alcohol in Humans and Laboratory Animals," *Science*, 209, 1980.

[8]K.L. Jones, D.W. Smith, C. Ulleland and A.P. Streissguth, "Patterns of Malformation in Offspring of Chronic Alcoholic Mothers," *Lancet*, Vol. 1, 1973; F. Majewski, "Alcohol Embryopathy: Some Facts and Speculations about Pathogenesis," *Neurobehavioral Toxicology and Teratology*, 3, 1981; and D.W. Smith, "Alcohol Effects on the Fetus," R.H. Schwartz and S.J. Yaffe (Eds.), *Drug and Chemical Risks to the Fetus and Newborn*, New York, Alan R. Liss, 1980.

[9]M. Lakin, "Personality Factors in Mothers of Excessively Crying Infants," *Monographs of the Society for Research in Child Development*, Vol. 64, 1957.

[10]A. Sameroff and J. Chandler, "Reproductive Risk and the Continuum of Caretaking Causality," in F.D. Horowitz (Ed.), *Review of Child Development Research*, Chicago, University of Chicago Press, Vol. 4, 1975.

[11]C. Black, "Characteristics of Children of Alcoholics," paper presented at the Annual Conference on Children of Alcoholics, Honolulu, Hawaii, Oct. 1985 and National Association for Children of Alcoholics, *Charter Statement*, 1983.

[12]D.E. Papalia and S.W. Olds, *Human Development*, New York, McGraw-Hill, Inc., 1978.

[13]R.J. Ackerman, *Children of Alcoholics*, Holmes Beach, Fla., Learning Publications, Inc., 1983.

Resources

Alcoholics Anonymous (AA)
P.O. Box 459
Grand Central Station
New York, NY 10163
(212) 686-1100

With more than one million members in 114 countries, AA is the largest self-help group for recovering alcoholics and problem drinkers. Local groups are listed in most telephone directories.

Al-Anon Family Group Headquarters
1372 Broadway
New York, NY 10018
(212) 683-1771

Al-Anon Family Groups, which include Al-Anon for adults and Alateen for youth, are self-help groups for family members and friends of problem drinkers. Local groups are listed in most telephone directories.

Children of Alcoholics Foundation
540 Madison Ave.
23rd Floor
New York, NY 10022
(212) 980-5394

The Children of Alcoholics Foundation is a voluntary, nonprofit foundation established to increase public awareness of the problems of children and young people from families with alcoholic parents. Publications include *A Review of the Literature* and *Report of the Conference on Research Needs and Opportunities for Children of Alcoholics*.

National Association for Children of Alcoholics (NACoA)
31706 Coast Highway
Suite 201
South Laguna, CA 92677
(714) 499-3889

Incorporated in 1982, NACoA is a national, nonprofit association for children of alcoholics in all age groups. NACoA publishes a quarterly newsletter and hosts an annual convention. The 2nd Annual National Convention will be held Feb. 23-27, 1986, in Washington, D.C.

National Clearinghouse for Alcohol Information
P.O. Box 2345
Rockville, MD 20852
(301) 468-2600

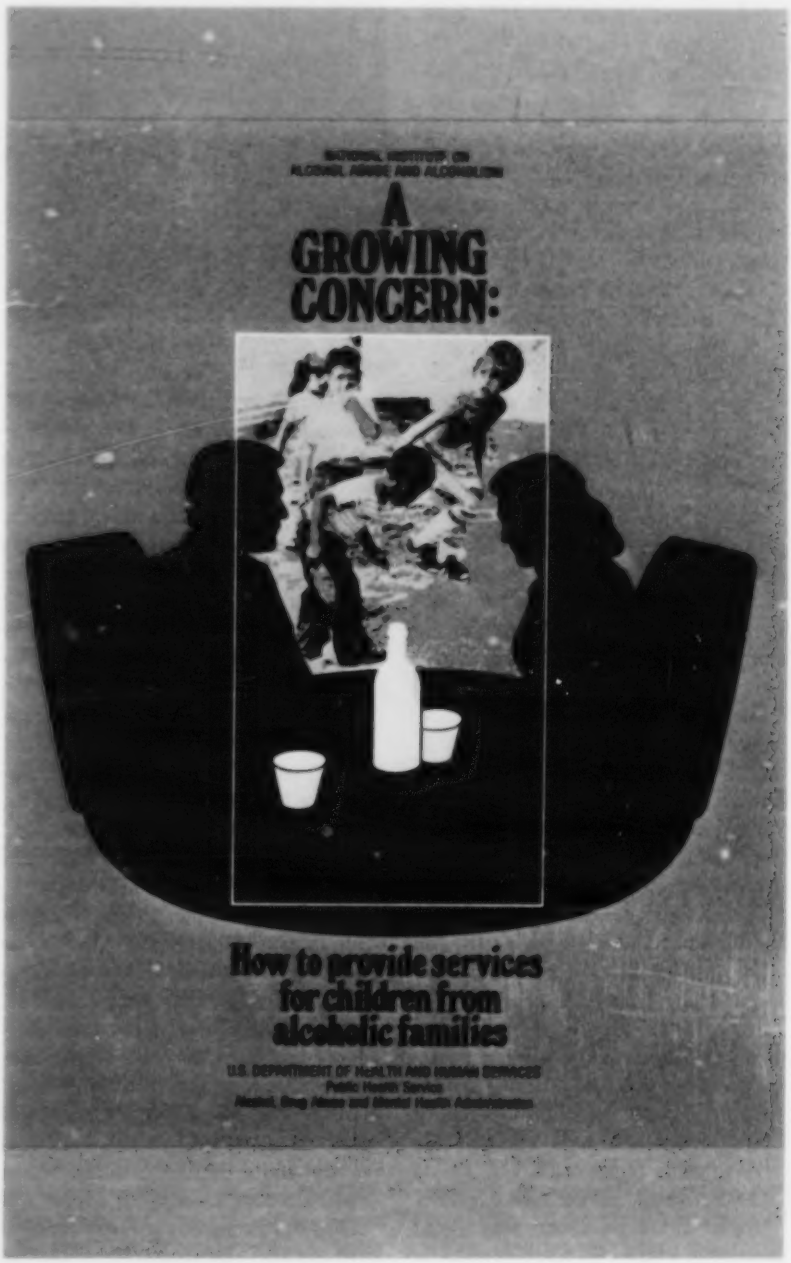
An information service of the National Institute on Alcohol Abuse and Alcohol, the Clearinghouse is the largest, most comprehensive resource for alcohol information in the world. The Clearinghouse also produces *Alcohol Health and Research World*, a quarterly magazine, and *Alcohol Awareness Service*, a bimonthly information service.

National Council on Alcoholism, Inc.
12 W. 21st St.
New York, NY 10010
(212) 206-6770

The NCA is a national voluntary health agency that provides information about alcoholism and alcohol problems through its local affiliates. Some of the NCA's affiliates provide counseling of alcoholics and their families.

Helping Children From Alcoholic Families: Approaches and Caregivers

Editor's note: The following article is adapted from Chapter II of A Growing Concern: How to Provide Services for Children from Alcoholic Families, *published by the National Institute on Alcohol Abuse and Alcoholism and distributed by the National Clearinghouse for Alcohol Information. In addition to providing an overview of the problems and needs of children of alcoholics, and approaches to meeting these needs, the book examines organizational and cultural issues in delivering services to children of alcoholic families.*



In providing services to children of alcoholics, caregivers have started to cross over to each other's settings and integrate each other's professional fields, setting precedents in an area where little has been accomplished.

Historically, children of alcoholics have been treated for the symptoms of living in an alcoholic family, such as child abuse, incest, troubled behavior, poor grades and school absences and depression. Experts in services to children of alcoholics emphasize that caregiving starts with the competence to see past these symptoms and identify family alcoholism as the problem. An effective community service system develops this competence in all its service providers.

Caregivers for children of alcoholics may be school personnel, including teachers, counselors and nurses; medical personnel, including doctors, nurses and psychiatrists; social service counselors, psychologists and psychiatric social workers; youth workers and law enforcement personnel; recreation

personnel, including volunteers and experts in youth recreation and sports activities; and church representatives.

The Schools

The school is a major institution involved in alcohol abuse prevention. Over the past 10 years, as substance abuse on school grounds has become a community issue, schools have tried innovative programs, even combining education with undercover law enforcement.

Schools are constrained by the concerns and rights of parents in the kinds of programs they can offer. Treatment or counseling, other than the accepted activities of guidance counselors and nurses, must be approved by parents. Therefore, reaching children of alcoholics, even through approved treatment programs, can be especially difficult, as the alcoholic and the nondrinking spouse may deny that there is a problem and may well discourage their children from talking to strangers about their family life.

Still, schools are an ideal place to perform the following services for children of alcoholics: information sessions about alcoholism and alcohol use; referral to community agencies for special services; school peer groups to discuss adolescent problems and alcohol issues; preparation and acquaintance with Alateen; and identification of children of alcoholics through supportive alcohol education programs.

Generally, teachers have been involved in education activities and school counselors or nurses in referrals. However, Triplett and Arneson interviewed school nurses attending a national professional convention and found that, although the nurses recognized problems symptomatic of living in an alcoholic family, most felt they needed more knowledge and skills before they could consider becoming deeply involved with the children displaying these symptoms.[1]

Two program models have been developed to train teachers and social workers to address the needs of children

of alcoholics in schools. The Student Assistance Program uses professional counselors to provide alcohol and other drug abuse intervention and prevention services for high school students who have alcoholic or drug-abusing parents, have themselves been abusing alcohol or other drugs, or exhibit behavioral and academic problems or signs of stress that could be related to their own or their parents' abuse of alcohol or other drugs.

Developed by the Westchester County, New York, Department of Community Mental Health, the Student Assistance Program was introduced in the Westchester County public schools in 1979-80 and has since been replicated in schools throughout the country.[2]

The CASPAR (Cambridge-Somerville Program for Alcoholism Rehabilitation) Alcohol Education Program in Somerville, Mass., has developed both school- and community-based programs for children and adolescents from alcoholic families. Groups for elementary school-aged children are co-led by a CASPAR staff person and a CASPAR-trained school staff member, usually an adjustment counselor or resource room teacher. Groups for adolescents are conducted after school by peer leaders, high school students who are extensively trained and supervised.

CASPAR's curriculum, *Decisions About Drinking*, has been purchased by more than 1,500 schools and agencies. In 1978, the model was selected by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) to be replicated nationally.[3]

The advantage of reaching children of alcoholics through school education and peer counseling programs is that the students are already in an environment in which they feel relatively comfortable. They do not have to initiate contact with a community agency or treatment setting. In addition, school and peer counseling programs can reach a larger number of children than a treatment or prevention program in an agency treating alcoholics.

There are also disadvantages to conducting counseling programs in school. First, the school program can become so convenient that participants do not follow recommendations to participate in treatment programs or in Alateen. Students may come to rely on peers or teachers to solve problems for them, although solving their problems may require more sophisticated knowledge

than peers or teachers possess. Therefore, it is especially important that school personnel attempting to reach children of alcoholics establish good relationships for referral with community agencies and private treatment providers. Often this will require educating child welfare agencies, child protective agencies and juvenile justice personnel to look at children's behaviors as the symptoms of living in an alcoholic family.

Youth Agencies and Associations

This broad group includes correctional halfway houses for runaways and youth with substance abuse problems, recreational associations in communities and churches sponsoring youth social development.

The potential caregivers in each setting are equally diverse in background and training. There may be mostly volunteers in a local Big Brother program, in addition to experienced youth workers and social workers. In halfway houses, there may be a range of certified and noncertified substance abuse counselors and outreach workers. Church-sponsored youth groups may be under the guidance of ministers or trained social workers.

The variety of caregivers indicates that different strategies to identify and serve children of alcoholics will be appropriate depending upon the expertise represented among the personnel in each setting. Identification of children of alcoholics is facilitated by the intake procedures in correctional and runaway centers. Identification in voluntary associations like the Boy Scouts or church social clubs would be more informal, probably through knowledge of youth over a period of time.

If these settings are sponsored by local government health and youth departments, some of the caregivers will likely be certified as professional counselors. In this case, education and even therapy groups may be possible for treatment and prevention approaches, with the permission of parents. If youths are ordered to these settings by the juvenile justice system, treatment would not require the permission of parents.

The advantages of reaching children of alcoholics through youth-related settings stem from the interest and needs that bring young people to them. Some youths must participate because of a court order. Some have nowhere else to live. Youths who are voluntary participants in social clubs or recreation associations have a level of interest upon entering the group that facilitates involving them in other activities.

The disadvantages of these settings relate to inconsistency of training among the caregivers. Where no treatment program can be established to help children of alcoholics identified at the setting, referral resources and relationships with appropriate treatment settings are essential.

Treatment Settings

Treatment settings include hospitals and private and public agencies. The caregivers typically found here include physicians, nurses, psychologists, psychiatrists, social workers and alcoholism counselors. Although they may be trained in the nature of alcoholism and its effects on the individual and the family, there is little effort underway to train professionals in these fields to be advocates for children of alcoholics.

Treatment settings can provide services for the whole family, including family therapy and family alcoholism treatment. Groups can be sponsored for education and therapy of spouses, other relatives and children. Educational groups for children may coincide with those for parents. In such groups, children can deal with their feelings about family alcoholism and be helped in their development of healthy responses to the family situation. They can be introduced to Alateen as their parents participate in AA and Al-Anon. Children and parents can be counseled together to improve their relationships with one another.

The chief advantage of a treatment setting is the potential for identifying children of alcoholics and involving them in treatment corresponding to that of their parents. However, some treatment settings focus on the alcoholic alone or on the alcoholic and the nondrinking spouse. In other settings, where children are being treated for

emotional problems, caregivers have not been as involved as they could be in identifying parental alcoholism as a possible cause of the children's problems. Therefore, family alcoholism itself does not become the object of the treatment strategy.

Rustin has written about the role that physicians and nurses should take in identifying family alcoholism and focusing treatment efforts on this.[4] Because of their knowledge of the medical symptoms of alcoholism, physicians are in an excellent position to diagnose alcoholism and its effect on the family as the problem. Unfortunately, many physicians prefer to focus on the medical consequences of the illness alone.

Professional associations for medical and therapeutic personnel could support a change in the way their members treat family alcoholism. Some professional associations, such as the one representing social workers, do specifically refer to the problems of children of alcoholics in their statements on alcoholism. Policy statements and the support of training efforts in professional degree-granting programs would help focus caregivers' attention on the problems of children of alcoholics.

The constraints on treatment settings in reaching children of alcoholics relate to the processes by which they receive clients. Hospitals help alcoholics and family members when a serious medical or psychiatric problem exists, but other family members are not generally brought into an accompanying treatment program. Agencies that provide residential or outpatient services for recovering alcoholics are limited in reaching other members of the alcoholic family or the children of alcoholics, unless these potential clients are referred through other health and social service institutions. Therefore, the relationships between treatment settings are especially important in reaching alcoholics and their families.

Once in place, coordinated intake and identification procedures and decision-making approaches for referral should facilitate assistance to all members of an alcoholic's family and decrease the chances that children will fall through the cracks of the system of health services. The expansion of services is also important. Bringing on full- or part-time caregivers who are specialists in the problems of children, or even sharing such specialists between treatment facilities, will increase the kinds of services provided. Because they see only the families of the alcoholics they treat, treatment setting personnel are sometimes limited in their clientele. Expanding services with skilled caregivers will enable staff in the treatment setting to reach out with prevention and identification services to other treatment and referral sources in the community.

Conclusion

Almost anyone can be a caregiver. Some professionals provide services directly related to family alcoholism; others can support efforts by direct service providers by identifying and referring children of alcoholics. Whether one is a direct service provider or acting in a referral capacity, some general and specific training is necessary. General knowledge about alcoholism, alcohol and the effects of alcoholism on the family are basic and required. Then, depending upon the setting in which one works, one's background and experience in the alcoholism field and the contact one has with children, special training experiences should be developed.

Since it was founded, NIAAA has sponsored the development of numerous training programs for all types of caregivers. However, changes in policy and funding during the 1980s will affect the development and availability of these programs. It will most likely be incumbent upon the National Council on Alcoholism (NCA) and its community affiliates, professional associations, and local, state and regional mental and physical health services to maintain a concern about the sponsorship of this training for caregivers working with children of alcoholics.

Training is important, but caregivers are sometimes additionally limited in their response to the needs of children of alcoholics by the settings in which they work. Traditional response strategies of identification, intervention, treatment and prevention are appropriate to certain settings. For example, prevention activities like alcohol education classes are accepted in schools. Prevention activities are also appropriate in alcoholism treatment agencies. Caregivers and potential caregivers must weigh the advantages and disadvantages of a particular strategy, considering the number of clients they will reach, the kind of help they can provide, the limitations of their own training and the constraints of their setting.

A number of gaps exist in providing service to children of alcoholics, many due to a lack of foresight and a coordinated approach. These gaps include lack of coordinated relationships among funding, regulatory and service agencies; lack of knowledge dissemination; lack of active programs and materials development; lack of caregiver training; and lack of research on the characteristics and needs of children of alcoholics. Resources should be devoted to narrowing these gaps. Support for services to children of alcoholics would probably motivate more individuals to reach out and offer help. ■

[1] J.L. Triplett and S.W. Arneson, "Children of Alcoholic Parents: A Neglected Issue," *Journal of School Health*, Dec. 1978.

[2] See *Preventing Alcohol Problems Through A Student Assistance Program*, DHHS Pub. No. (ADM) 84-1344, available from the National Clearinghouse for Alcohol Information, P.O. Box 2345, Rockville, Md. 20852, and Ellen Morehouse and Claire Scola, *Children of Alcoholics: Meeting the Needs of the Young COA in the School Setting*. South Laguna, Calif., National Association for Children of Alcoholics, 1985. Further information may also be obtained from Student Assistance Services, 228 Fisher Ave., White Plains, N.Y. 10606.

[3] Further information on CASPAR curriculum materials and training workshops may be obtained from Dr. Ruth B. Davis, Director, CASPAR Alcohol Education Program, 226 Highland Ave., Somerville, Mass. 02143.

[4] T. Rustin, "Physician Participation in Intervention," paper presented at the National Council on Alcoholism Annual Forum, New Orleans, 1981.

Non-Formal Education

Photo: Girls Clubs of America, Inc.

in Organizations for American Youth

by Judith B. Erickson

• A large group of youngsters waits to go on stage at the Minnesota State Fair. Most are black, and all are from inner-city Minneapolis. Some are in leotards while others wear the stark white make-up of traditional mime theater. The show begins and the troupers from the 4-H Urban Arts Program go through their paces to the delight of onlookers, most of whom seem surprised at this departure from the expected demonstrations of sewing a fine seam or putting up the garden harvest.

• On a hot July evening, long columns of khaki-clad boys and men raise the dust as they pour forth from the tent city of 32,000 which has sprung up overnight on the normally empty acres of Virginia's Fort A.P. Hill. After six hours of music and pageantry, including a concert by the Beach Boys, the National Jamboree and 75th anniversary celebration of Boy Scouting is off to a rousing start. The next day's appearance of Hurricane Bob only slightly daunts and temporarily dampens the spirits and sleeping bags of Scouts gathered from every state and territory and 32 foreign countries. Thousands of visitors, many in their own uniforms of decades past, testify to the reality of the theme chosen for the occasion: The Spirit Lives On!

• A club of young boys quiets down as their 11-year-old president carries them skillfully through the business of the day. That concluded, the agenda turns to a discussion of an outing of a few days earlier when they had gone to see "The Killing Fields," a powerful film about the conflict in Southeast Asia. A reporter from the *Los Angeles Times*, who is a guest at this Camp Fire meeting, is astounded at the depth and sophistication of their commentary. Such exchanges are encouraged through the peace education program recently introduced by the national organization.

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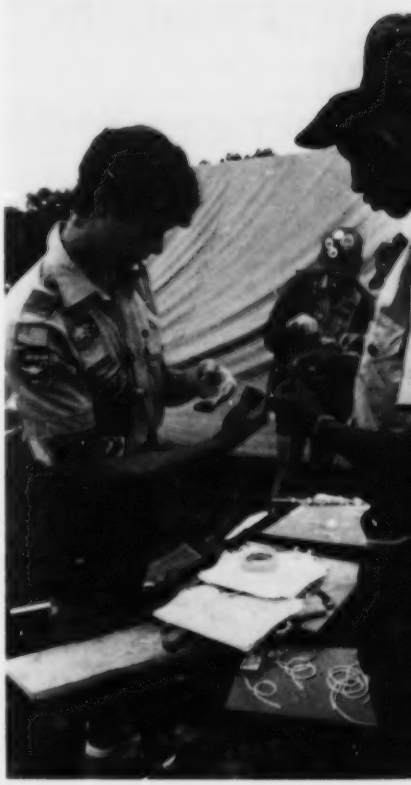
Above and opposite page, top: Over the years the Y.M.C.A. has become family-centered, with programs for all members of emerging family types and lifestyles (photos by Nora Kengle for the YMCA of Metropolitan Washington). Below and opposite page, Boy Scouts celebrate their 75th anniversary (photos courtesy Boy Scouts of America).

A bright yellow bus empties its chattering cargo into a large brick building on Omaha's north side. Soon some of the arrivals are coercing their bodies into the unfamiliar postures of classical ballet; others are attacking homework problems, stopping occasionally to seek assistance. Elsewhere, several more are engaged in discussion of the serious business of learning to be responsible for their own safety in a world where they are often on their own. In the kitchen, still others are helping to prepare the evening meal. It is a routine afternoon at the Girls Club.



These are but four samples of non-formal education, on scales large and small, going on in organizations for American youth in the mid-1980s. At present, there are more than 300 national youth associations, meeting in and out of school and ranging in size from the few hundreds of the Cherokee Nation Youth Leadership Program to the more than 4.4 million in 4-H. These groups vary also in the scope and content of programs, the socioeconomic and ethnic composition of the membership, and in the range of options and opportunities available to youth and adult members. In spite of such differences, they share in common the mission of transferring parts of the nation's cultural heritage—beliefs, skills, attitudes, values—to young Americans gathered in troops, groups and teams under adult guidance.

Non-formal education has diverse origins in the apprenticeship systems and sodalities of Western childhoods past. In the United States, however, de-

velopment of organizations for the socialization of children and adolescents did not truly get under way until the 1830s, and thereafter growth paralleled entry of the young in larger numbers, and for longer periods of their lives, into the schools and academies of the formal system that began to replace in-home and on-the-job training for adult roles. The earliest groups were autonomous, dedicated to such worthy purposes as prayer, support of foreign missions, mutual improvement and debate over current issues. More at the fringe of adult approbation were groups such as the juvenile militia units that drilled on village commons and adjourned later to village pubs to recover from their exertions. These early societies often embraced members ranging from ages we would now term early childhood to early adulthood. The latter, presumably, were expected to wield some measure of charge over the former.

Adults began to assume more control over the activities of youth groups when middle-class volunteers, flush from their successes with poor children in the Sabbath schools, turned their sense of duty toward their own young and formed juvenile branches of the numerous reform societies—missions, abolition, peace and, particularly, temperance—in which they were also involved. It was in the battle against King Alcohol, beginning with the Cold Water Armies in 1836, extending through the mid-century Bands of Hope and, finally, the Loyal Temperance Legions of the 1870s onward, that most of the varied forms and methods of non-formal education were initiated. It was not until after the turn of the century, however, that all of the elements were worked into successful formulae which would both serve adult purposes and attract and hold large numbers of young members.

Bridging the Gaps

Non-formal education came into its own in the first two decades of the 20th Century, and the developers of youth organizations were closely associated with the broader movements of Progressive Reform. Most of the major nonsectarian programs serving today's youth were either founded or formalized between 1904 and 1919, as structures to bridge the socialization gaps that were appearing between home and school. Although this era seems to share few similarities with our own in such respects as available technology, prevailing moral values and uses of leisure time, there are similarities in some of the forces that stimulated the formation of youth organizations and those that challenge their continued well-being today. Changes in two areas, family and economic roles, have had, and continue to have, particular impact upon the structures and programs of youth-serving organizations.

In a little over a century, the "ideal" middle-class family had changed from an interdependent rural/small-town economic production unit with much sharing of activities and overlapping of roles, to an urban-dwelling consumption unit in which each member had a functionally-specific place. The male family head of 1900, as sole breadwinner, felt he had earned the right to respite in a comfortable home maintained by a domestically accomplished (though economically dependent) wife, and respect from children he was preparing for upward mobility by maintaining them in educational institutions throughout their adolescence.

In pursuit of this ideal, not only were women and children being withdrawn (or increasingly, legally withheld) from the workforce, but the nature of the work which men (and to a lesser extent, women) might realistically anticipate in their lifetimes was changing, as well. Yeoman farmers, or at least their children, were deserting their fields, while dreams of artisan-shop or small-business ownership were giving way to probabilities of wage labor or, if fortune smiled, salaried managerial situations in the developing mass industrial economy. Increasingly, life was being lived in cities; the 1920 census revealed that Americans, for the first time, had tipped the balance in favor of urban residence. Here, men, women and children were spending their days in the separate worlds of workplace, home and school.

Separation was also extending to social life. Membership in male clubs and fraternal orders was at an all-time high; women were joining auxiliary groups as well as developing social and philanthropic networks for purposes related to their own worlds. For their part, young people were also attempting to develop an associational life—sometimes gathering for purposes which their elders found less than worthy.

The development of adult-sponsored leisure-time organizations has been seen by some historians as a response to the need for greater control over young lives. Although most parents of the day no longer felt it their primary duty to crush out original sin in their offspring, few were convinced that idle hands could be other than the devil's playthings. Amusement as an end in itself was still on uncertain ground. Thus, it is to a degree true that acknowledgment of youths' own social needs was frequently coupled with an attempt to employ their leisure time for adult-defined ends. There were, however, other motivations present. Parents were genuinely concerned with providing their children with a start in life that would fit them for futures likely to be quite different from the adult lives for which they themselves had been prepared. The socialization of males for a frontier-conquering individualism was less appropriate for sons who would become foremen or members of the "white collar" managerial class. Similarly, the preparation of women for a homebound domesticity seemed insufficient for daughters who would be expected to bring their special "civilizing" qualities to the community at large. A new set of models was needed for both young men and young women. They had to be prepared to work as team members—providing or accepting supervision as the occasion demanded—yet they also had to be astute enough to recognize, and plucky enough to turn to their advantage, such opportunities as came their way. Above all, they had to have Character. Such was the task facing the educational system.

There were those who felt it to be too great a task for the schools alone. Sir Robert S.S. Baden-Powell, who created the first widely successful movement for adolescent boys, was one of them. Book learning, while it had its place for instilling knowledge, left a number of "chinks" of equal importance in a young man's education for good citizenship; among them, he noted Character, Physical Health, Handicraft for Making a Career, and Service to Others.

Boy Scouting was his blueprint for filling the gaps. Its most important aim was "to educate; not to instruct, mind you, but to educate, that is, to draw out the boy to learn for himself, of his own desire, the things that tend to build up character in him." What Scouting offered was a series of activities, often meaningful and fun in and of themselves, which would serve to inculcate the desired qualities and the "attributes which they include."[1]

The organizations that followed the Boy Scouts also asserted their educational function. Juliette Low, writing of the Girl Scout organization which she founded, said that its declared purpose was "to promote the virtues of womanhood by training girls to recognize their obligations to God and country, to prepare for duties devolving upon women in the home, in society and the State, and to guide them in ways conducive to personal honor and the public good"; in other words, to train girls for citizenship in the broadest sense. Girl Scout troops are the adolescent girl's laboratory courses in the school of living. Thus, the Girl Scouts' educational program supplements and strengthens the educational efforts of both the home and the school.[2]

Camp Fire Girls was designed very consciously to complement the Boy Scouts of America by taking into account "sex differences in social responsibility." In 1912 Founder Luther Halsey Gulick explained to the National Education Association:

"If ever woman was needed, it is today. The very riot of our material riches is the peril of our souls. Woman is already taking hold of the present material world, giving to it and bringing into it the love and service and spiritual relations which in the old days created the home and which today are changing the man-made workhouse into a place adequate to the glorious future life of human beings.

"The Camp Fire Girls is an organization which . . . is a deliberate attempt to help meet the new and splendid social world which is before us."[3]

The Y.W.C.A., which first supported the Camp Fire organization (like the Y.M.C.A., which had supported

the Boy Scouts), launched a formal club program of its own in 1918, along more directly Christian lines. The Girl Reserves were to "educate in standards of life, to widen interests, to meet the vivid demand of the quick-pulsed 'teens for something to *do*, to train through activities, to supply good nourishment to the sudden hunger for extracurricular information and experience that are for ever budding overnight in adolescence."[4]

Junior Achievement had more specific educational aims. It was designed "to take the place of the lost apprenticeship system of shop, store, and factory in a pathfinding program for our children." Character-building was not omitted, however, for the organization was also "to supplement the home in helping boys and girls, through efficient leadership, to do things, salvage their idle hours and their available energies in training in some of the useful occupations and getting acquainted with the processes of work in factory, store, and business."[5]

The 4-H Club program of the U.S. Department of Agriculture, on which Junior Achievement was modeled, hoped that its program would lead to a "better type of farmers and home builders." It also had an additional purpose—that of using successful youth projects as a way of educating the elders, who were often reluctant to adopt the "best farm and home practices" being developed in the land-grant universities that were the home of the Extension Service and its youth arm.

Photo: Girls Clubs of America, Inc.

Girls Clubs, one of the youngest of the national youth-serving organizations, retains its commitment to serving girls.

Each organization, although somewhat different in emphasis and program, was designed as an action-oriented, non-formal educational supplement to home and school. Over the years, the founders' educational aims appear to have given way to more recreational and, in some instances, to therapeutic intervention purposes. In the last decade or so, social changes have been drawing them back to their origins. The mass industrial economy is becoming the "information society" in an economy based primarily upon service provision. New role requirements are being imposed on its workers. Moreover, the relationship of women and youth to the labor force is again an issue. Whereas at the beginning of the 20th Century the middle-class ideal was to keep them out of the workplace, the problem for the end of the century is to effect their re-entry on rational and equitable terms. These changes have had broad impact on the structure and functions of youth organizations as they seek to maintain (or catch up with) the supporting services needed by today's young as they prepare for futures which will, again, be very different from the lives of their parents. It is possible here to discuss but a few of the recent changes in membership and leadership that have been taking place.

Membership

Who shall be served? This issue has been faced by all of the organizations. While it once seemed appropriate to prepare boys and girls for their separate spheres of adult life in single-sex organizations, the facts that a majority of women will also need to be competitive in the labor force for much or all of their adult lives, and that households, in effect, are once again economically interdependent units of working adults and adolescents, have called into question the wisdom of such division.

The youth organizations have responded in various ways. The Y.M.C.A. has become family-centered, with programs for all members of emerging family types and lifestyles. The Big Brothers and Big Sisters organizations faced the issue by merging in 1977. The Boys Clubs began admitting girls in the early 1970s, although they have only recently begun to consider their special program needs. Boy Scouting has retained its traditional advancement program for boys only, but the career-oriented Exploring Division was opened to young women in 1971. 4-H Clubs and Junior Achievement, always strongly vocational in their program emphases, began and remain co-educational, as does the community service-oriented youth program of the American Red Cross. While the Y.W.C.A. still admits only females to membership, associate status is given to young men who participate in many local programs. The Girl Scouts, on the other hand, welcome men as adult volunteer members but offer their services to girls only.

The Girls Clubs, the youngest of the national organizations included in this discussion, have been placed under considerable pressure in many communities to merge with Boys Clubs, and in a few instances they have done so. At the national level, however, the organization retains its commitment to serving girls, feeling that even "equal" programming would be insufficient to compensate for the multiple disadvantages of gender, ethnic minority status and poverty faced by so many of their members. The boldest change under-

taken by any of the organizations was the "New Day Program" initiated in 1975 by Camp Fire, perhaps the most traditional of the girl-serving organizations. Although the emphasis on the club program for 6- to 17-year-olds was retained, the entire program was redesigned on non-sexist lines to include boys and to permit delivery of services to youths from birth to age 21.

Camp Fire has not been the only group to alter the age structure of its membership. The Y.M.C.A. offers programming for all youths, beginning with such activities as "water enrichment" for parents and infants. The group- and troop-based programs were designed originally for adolescents, but within a few years of their founding younger children successfully pressed for admission. Most recently, the Boy Scouts have added the Tiger Cubs for 2nd-grade boys and an adult family member. It is expected that this program will be offered to 1st-grade boys within the next two years. And in 1984-85, the Girl Scouts, who had already extended the Brownie program to 1st-graders, began full implementation of the Daisy program for 5-year-olds. Current membership statistics for 11 youth-serving organizations are presented in Table 1. As may be seen, the groups have varied widely in their growth patterns over the past six years.

Leadership

The issue of who shall lead has also become important in recent years. All of the youth agencies have relied heavily on volunteers to deliver actual program services. The professional staffs of the 11 organizations were estimated at 27,660 in 1978, while the number of volunteers working directly with youth on a regular basis topped 1,675,400—a ratio of more than 60 to one. Many thousands more worked occasionally with youth, and some 718,000 volunteer board members set organization policy.[6] The figures would probably vary somewhat from one organization to another in 1985 but overall would not differ greatly. A persistent problem for youth-serving organizations is the salaries, particularly at the entry level, that professional youth workers are paid. Table 2 presents a review of placements and salaries of 1983-84 graduates of the American Humanics program in youth and human service agency administration.

Some of the 32,000 Boy Scouts attending the National Jamboree set up camp.

The "motherforce" on which many of the organizations relied for voluntary leaders has not only returned to the labor force in large numbers but has established new priorities—often related to personal and/or professional development—for their more limited volunteer time. This has been exacerbated by the fact that so many women are managing households alone. Many of the organizations have turned to adults other than parents for group leadership—single adults and retired individuals and couples, for example. In some cases, high school youths lead troops, clubs and teams. One potential leadership source that appears to be under-utilized is the non-custodial parent. Assuming, of course, that no pathology was involved in the family breakup, it would seem that working with their children's youth groups might provide non-custodial parents with greater access to more of their children's lives than the weekly visits to fast-food restaurants and the zoo that too often form the basis of many relationships. Not only would the important parent/child bond be strengthened, but such an overt demonstration of concern could have special meaning and value to the children as well.

Another unexploited source of youth group leadership is found within corporations that provide release time (with pay) for employees for civic involvement. Given the complex networks and absentee management that mark much of the corporate world, such policies are sometimes hard to uncover and implement at the local level; the benefits they offer, however, make it worthwhile to pursue them.[7]

While many youth organizations have established new patterns of leadership, the Boy Scouts have retained the rule that only adult males shall be Scoutmasters or Assistants. Currently under court challenge, this policy has implications beyond the issue of whether a private-sector organization ought to be able to set its own course. In a society that provides few models for nurturance by adult males, Boy Scouting (along with other youth organizations) has not only permitted such roles but has taught men how to enact them. Although the time may come when men will assume an equal partnership in the rearing of their children, it seems premature at present to turn this relationship over to mothers, as one would predict would be the case,

Photo: Boy Scouts of America

if the option were available.

Apart from these problems of securing adult leaders, state and federal legislation that is enacted and being implemented following the discovery of the pervasiveness of child abuse in American society may prove to be the biggest challenge to date to youth organizations' dependence on volunteers. Big Brothers/Big Sisters, which matches young people in a one-to-one relationship with adult friends, has taken the lead in developing procedures for screening volunteers. Such examinations are costly—typically ranging from $200 to $300 each—and time-consuming, and often meet with poor cooperation from authorities. Furthermore, funding bodies have not taken this added expense into account in making allocations, which has resulted, in some instances, in curtailment of services to youth. As vetting requirements for youth workers increase, as it appears they must, many agencies are likely to find themselves in financial crisis if they attempt to maintain current levels of service provision through volunteer leadership.

Summary

While the uniforms may be updated, in many other respects today's youth organizations would be recognizable to their founders. Over the decades, their programs have been offered to millions of American young people. At their best, they provide access to interesting and concerned adult friends, social and technical resources, and meaningful roles in the broader community—all difficult for youths to obtain readily on their own. For some, undoubtedly, "the touch was too light," as one youth worker put it, to have any real impact on their lives, but for many, these groups have extended a set of standards to be internalized and lived throughout their lives.

It is of more than passing interest that each of the "chinks" in the educational structure noted by Baden-Powell in 1920—character, physical health, employability and service to others—has been identified as lacking in the youth of today and forms the focus of a movement for educational reform. Over the years, school reform has at best been isolated, fragmented and temporary, giving us little reason to hope that current efforts, if they are to take place within the formal system only, will produce and sustain the changes desired. It would seem that the time is right to attempt to forge a partnership between formal and non-formal education, in which the latter is taken seriously, provided with resources and held accountable for the tasks undertaken.

One must admit that there is much to draw a smile in the operations of organizations for youth. Earnest, bedecked young (and not so young) men in hiking shorts, the mismatched voices of singing fathers and daughters sitting cross-legged in a circle on the floor, or determined, green-clad young ladies peddling cookies are but a few of the images that come readily to mind. But such images are only a part of the total picture. The real purpose of these groups is to connect old-fashioned goodness with the habits of daily life while they are in formation. The need remains, as a recent Carnegie Foundation Report asserts:

"A tension always exists between the centripetal forces of public interest and the centrifugal forces of individual interest. There are times, however, when individuals must take a broader and longer view in order to exercise power for the common good. The wise exercise of this power, the founding fathers argued, depends on the education of the public. If there is a crisis in education in the United States today, it is less that test scores have declined than it is that we have failed to provide the education for citizenship which is still the most significant responsibility of the nation's schools and colleges."[8]

It remains to be seen whether the group of organizations for youth can be brought effectively into an educational partnership with the public and private schools of the nation. It would seem to depend upon the youth organizations' recapturing the educational role envisioned by their founders, refining it to contemporary realities and coordinating their efforts. These organizations must assess carefully what their three-quarters of a century of experience has taught them to do particularly well, and put that experience to the service of the youth of today and tomorrow. ■

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[1]Sir Robert Baden-Powell, *Scoutmastership: A Handbook for Scoutmasters on the Theory of Scout Training*, American Edition, New York, G.P. Putnam's Sons, 1920.

[2]Juliette Low, "Girl Scouts As An Educational Force," *Bulletin No. 33*, Washington, D.C., Bureau of Education, Dept. of the Interior, 1919.

[3]Luther H. Gulick, "The Camp Fire Girls and the New Relation of Women to the World," in *Proceedings of the National Education Association*, 50, 1912.

[4]Education and Research Division, National Board of Y.W.C.A., "Educational Work of the Young Women's Christian Association," *Bulletin No. 26*, Washington, D.C., Bureau of Education, Dept. of the Interior, 1923.

[5]William A. Mays, *The Junior Achievement Movement: An Examination of Its Psychological, Economical, Political, and Educational Significance*, unpublished Ph.D. dissertation, Ohio State University, 1954.

[6]The 1978 figures were drawn from D. James, *Description Study of Selected National Youth Serving Organizations*, Washington, D.C., Science and Education Administration/Extension, U.S. Department of Agriculture, 1979.

[7]K.K. Allen, *et al.*, *Volunteers from the Workplace*, Washington, D.C., National Center for Voluntary Action, 1979.

[8]F. Newman, *Higher Education and the American Resurgence*, draft, Carnegie Foundation for the Advancement of Teaching, Sept. 16, 1985.

Table 1. YOUTH SERVED BY SELECTED AMERICAN ORGANIZATIONS

Figures are for 1984 unless otherwise noted (Year of founding in parentheses)

				1984 Membership	% Change Since 1978[1]
American Red Cross (1917 as Junior Red Cross)					
School students involved in services				**2,453,504**	**N.A.**
Big Brothers (1904)/Big Sisters (1908) of America (Merged 1977)				**100,000**	**N.A.[2]**
Boy Scouts of America (1910)				**3,656,895**	**+11**
Tiger Cubs (Age 7)	**4% of Membership**				
Cub Scouts (7-10)	**41**				
Scouts (11-17)	**28**				
Varsity Scouts (11-17)	**1**				
Explorers (15-20)	**11**				
Career Awareness	**15**				
Boys Clubs of America (1906)				**1,275,00**	**+22[3]**
Age 6-7	**10%**				
8-10	**29**				
11-13	**33**				
14-18	**29**				
Camp Fire, Inc. (1910 as Camp Fire Girls)				**337,000[4]**	**N.A.**
4-H Program (1914)				**4,422,932[5]**	**−16**
Age 9-11	**61%**				
12-14	**27**				
15-19	**12**				
Girl Scouts of the USA (1912)[6]				**2,172,000**	**−14**
Daisies (Age 5)	**3%**				
Brownies (6-8)	**52**				
Juniors (9-11)	**34**				
Cadettes (12-14)	**7**				
Seniors (14-17)	**2**				
Not in Troops	**3**				
Girls Clubs of America (1945)				**200,000**	**−11**
Age 6-18					
Junior Achievement (1919)				**616,293**	**+107**
Companies (Grade 10-12)	**34%**				
Business Basics (5-6)	**16**				
Project Business (8-9)	**45**				
Applied Economics (11-12)	**4**				
YWCA (1851)			**Youth Served:**	**6,699,974[7]**	**+46**
Age 1-5	**Members: 17%**	**Oth. Part.: 21%**	**Members:**	**2,801,538**	**+9**
6-11	**59**	**50**			
12-17	**24**	**29**			
YWCA (1855)			**Youth Served:**	**203,098[8]**	**−37**
			Members:	**112,601**	**−47**
Female members, aged 12-17	**55%**				
Female non-members, 12-17	**27**				
Male associates, 12-17	**18**				

NOTES: [1]1978 figures are from D. James, *Description Study of Selected National Youth Serving Organizations*, Washington, DC, U.S. Dept. of Agriculture, SEA-Extension, 1979.

[2]BB/BS not included in 1978 study; 1979 BB/BS Annual Report lists 100,000 youth served; 60% of current population served is male, 40% female.

[3]Membership figure includes 300,000 girls (24%); since 1978, males served increased 10%, females 45%.

[4]Unduplicated service figure, 1984 through Aug. 1985.

[5]54% of the membership is female; 46% male.

[6]Figures are for September 30, 1985; 1985 is first year of full implementation of Daisy Program.

[7]47% of all youth served female; 45% of membership female. Among 12-17 year olds, 42% of the members are female. In the 12-17 age group, membership has declined by 19% since 1978, while there has been a 78% increase in the number of other registered participants in programs.

[8]Figures are for 1982.

This young woman became so involved with the day care lab run by her Future Homemakers of America chapter that she decided to pursue a career in early childhood education.

Photo: Future Homemakers of America, Inc.

Table 2. Annual Salaries of American Humanics Program

B.A. Level Graduates, 1983-84

	Boy-Serving Organizations	Girl-Serving Organizations	Coeducational Organizations	Other Youth and Human Service Agencies
Number of Placements	44	10	4	9
Average Full-Time Salary	$14,480	$12,660	$14,875	$14,722
Range of Salaries	$10-$18,000	$10-$15,600	$12,500-15,500	$12-20,000

Although expectations are similar in the various organizations, it is clear that those who go to work for girl-serving agencies are greatly disadvantaged. Among the agencies hiring both men and women, there was greatest salary equity in the Boy Scouts of America.

We Can Help Children To Be Self-Reliant

by Bernard Brown

All too often our good intentions for children take the form of doing things *for* children, of telling them what to do, of exerting control over them for their own good. It is rare that we step back and ask if our doing things for children takes away from their power to do things for themselves. Does our well-intentioned external control diminish their capacity for self-control both now and in the future?

Perhaps it is time to change our priorities from direct control aimed at stuffing the maximum possible amount of knowledge, skills and values into children to motivating them to manage their own lives—shifting the balance of our work with children from helping to enabling, from support to promoting self-reliance.

A frequently voiced concern about human service programs is that the very act of offering to help a person in need tends to make the person dependent upon the help offered. It has been claimed that in some cases people who might be able to cope by themselves become dependent on the programs and no longer make a full effort to meet their own needs. It would be inhumane to neglect the truly needy, but clearly it would be desirable to develop programs that enhance individuality rather than increase dependency. The issue is not whether children can be completely independent of their families; the issue is whether we can find better ways to help children grow into self-reliant individuals.

Our nation has developed vast institutions, such as schools, social agencies, hospitals and mental health services, to meet the needs of children. But these institutions have been organized so that their service providers do things for children, telling them what to do and think and feel. They rarely focus on helping the children manage their own lives to the greatest extent possible.

Today the vast majority of jobs are service jobs. Doctors, lawyers, teachers, salespeople and plumbers—and, of course, media reporters—work very hard trying to convince us that we should be dependent upon their services. The boundary between dependent behavior and appropriate use of services is rarely defined.

One way of dealing with dependency on social programs and service providers is a preventive approach that would work with children to help them grow up as self-reliant people who learn how to avoid needing help in the first place. How can we enhance self-reliance in children?

Components of Self-Reliance

What are the areas of competence that an individual must establish for optimum development of self-reliance?

1. Establish A Sense of Self

Awareness. To activate the self to its full potential, one must first be aware of it. Just as a baby gets feedback from a mirror about the appearance of her bodily self, our every thought and act is based on our perception of some aspect of the self. The awareness of our potential and the feedback signals that come from our bodies and the environment are the starting point from which we determine our position in the world. Awareness is thus the first step in the conscious direction and control of our behavior.

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Feedback is the beginning of control. As we learn to attend to the signals from our bodies, from our feelings, thoughts and behaviors, from our families and from our environments, we begin to know what is happening to us and what our potential is for changing what is happening to us. We learn to transform our behavior from the automatic level to the self-controlling level.

Independent Thinking. Independence is nurtured by providing children with opportunities and challenges to control their own lives and by promoting self-assertion—by encouraging them to make "I" statements, for example. Children can be encouraged to choose for themselves and to critically evaluate what they hear and read in terms of their self-interest. They develop independent thinking skills by independently dealing with the world. For this they need opportunity rather than support. The general rule is, "Do not do for children what they can do for themselves."

Social Independence. An independent person charts his or her own life and is not controlled by others, whether they be family members, friends, teachers or strangers. Children can learn to define and assert themselves and resist being defined by others. They can be helped to think and behave so that they are free of inappropriate control yet still act responsibly and lovingly.

2. Promote A Sense of Self-Worth and Competence

Self-Worth. Children who feel loved and esteemed are open to experience, feel free, are confident and feel a sense of power about shaping their own lives. By defining themselves with respect to their families they acquire a sense of being an individual so that they function autonomously according to self-selected goals. When children receive love and esteem, gain a sense of being an individual and experience success, they develop a sense of self-worth.

Self-Efficacy. Children can develop a sense of having power over their own lives by experiencing success. They need the opportunity to have a wide range of meaningful experiences (including some failures), which requires that adults let go and permit appropriate risks. Children also need feedback that reinforces a sense of competence. That is, they must be made aware of their successes and strengths. Children should always have a basis for hope of future success and have confidence that they will always be able to find a way to change their lives.

Choice. Children can learn to act by conscious choice rather than automatic obedience or reaction. To learn how to choose they need to be presented with choices. Of course, young children should not be overwhelmed with too many or too difficult choices. Adults can negotiate rather than order, point out multiple possibilities rather than suggest a single course of action and reward choosing behavior.

Environment. Over the long course of development, a calm, predictable environment will result in a child who will think his or her way through difficulties rather than react automatically with fear or other inappropriate emotions. When the brain is subjected to stress or to high emotions, it loses its power to reflect and a person tends to react to events in an automatic, unthinking way. Thought patterns then regress and lose precision and the sense of self diminishes. Stressful situations are improved when a person feels that the course of events is predictable. It is essential that parents provide children with an emotionally relaxed environment.

3. Promote Responsible, Disciplined Behavior

Responsibility. To be responsible is to be reliable, dependable and answerable for one's actions. When one acts responsibly, self-worth is increased. Children can be taught to develop behavioral repertoires, ways of dealing with the world that help them to behave in a responsible fashion. Responsibility requires a strong sense of self and strong discipline, as well as a sensitivity to the feelings of others and a sense of obligation to family, school, city and society.

Values and Standards. To control the self, children need values to give meaning to life's events and goals to guide their actions. They must learn to value self-worth, individual autonomy, re-

sponsibility to self and others, and the importance of making choices. In addition, in order to gauge their actions, they need behavioral standards, based on successes and failures in coping with life's problems. Values and standards provide internal feedback to help children decide whether or not their behavior meets the standards and to choose how they will act. They can then plan responsible and disciplined action to reach their goals.

Self-Discipline. The goal of external discipline is to help children learn how to achieve their goals so that dependence on pressure from others can be replaced with self-discipline. The highest level of discipline, that which maximizes self-worth, is self-discipline. When pressure must be applied to a child, always discipline in love so that the child's sense of self-worth is not harmed. To do so, punish the child for the behavior and not for being a bad person. Discipline should be realistic; rules must be obeyable. To acquire self-discipline a child should understand the reasons for being punished. Even before understanding the reason for being punished, the child must understand the reason for acting in a positive way and should be shown how to choose a positive path.

Training Children To Be Self-Reliant

The following three methods can be used very effectively to make children more self-reliant. These methods enable a child to overcome history and circumstance and rise to a new level of freedom.

- Behavioral Patterning. In contemporary psychotherapy, behavior modification is used widely and very successfully. The principle is simple: You become what you do. Act brave and you will become brave. Practice self-assertion and you will become self-assertive. Arrange for children to behave in appropriate ways and they will eventually grow into adults in whom the behavioral patterns have been transformed into strength and character.
- Expectation. Children are amazingly responsive to adult's expectations, both spoken and unspoken. They have astonishing capacity to accomplish the things expected of them. It is well known that adults overachieve when they are given hope, experience success, feel their own power, are motivated by a sense of potential gain or need, are cheered on or are influenced to believe they have special abilities. This overachievement must be set against the background of the adults' diminished sense of their own abilities in light of their failures. Without a long history of failure and inhibition, children are naturally endowed to move freely and effectively on the wings of adult expectations. In addition, they are quick to accede to the adult's wishes on small things, including the many minor behaviors that lead to the capacity to be self-reliant. They are also quick to add behaviors that are found to work to their repertoires. Expect children to think, feel and behave in a self-reliant manner and they will do so.
- Modeling. The most powerful way children learn about self-reliance is by watching the behavior of their parents, teachers and other significant adults in their lives. Adults can promote self-reliance by showing an awareness of their own identity and autonomy, by defining for themselves appropriate values and behavioral standards, by acting responsibly and by providing children with experiences that help them to grow into self-reliant adults. This is not simply imitation. It leaves children free to define themselves and learn their own styles of coping.

Conclusion

The struggle to attain self-reliance is in the final analysis a struggle for freedom, for the promise of America: life, liberty and the pursuit of happiness. It is a struggle to set one's own goals, to choose one's own way and to live as an independent, autonomous, self-actualizing individual. With self-reliance people can make up their own minds, exercise their own disciplines and seek out their own values and meanings in life. They can possess a sense of self-worth and a sense of power over events in their lives.

The alternative to self-reliance is to have no awareness or acceptance of one's self, to substitute emotion for thought and effective action, to react in an automatic way to the demands of others, and to be dependent upon—even to be enslaved to—other individuals and social institutions.

America's blessings are within the reach of all of us, but only the self-reliant have the power to grasp them in their fullest. For ultimately freedom is in the mind, which has the power to transform environment. To the extent that we bring our minds to a higher level of self-reliance we make ourselves freer people. And to the extent that we guide our children toward self-reliant behavior, we help create the conditions under which they can grow up as truly free men and women. ■

Making Children Self-Reliant

Parents, teachers, counselors and others involved with young children can take several steps to help them develop self-reliance.

To promote *self-awareness* in children:

- Teach children to look at themselves. Ask, "Do you think of yourself as smart . . . tall . . . strong . . . pretty?" Then ask them to look in the mirror and tell you what they see.
- Teach children to make self-evaluations. Ask, "Where did you go wrong?" and "What would you ask yourself before starting all over again?"

To promote *independent thinking:*

- Teach children to think for themselves: "I'll be happy to give you my opinion, but first tell me what you think."
- Before giving a child help, ask yourself if the job is really beyond the child's abilities and if, given more time, the child could handle it without your help.

To help children to be *socially independent:*

- Encourage children to say what they think and feel—and encourage them to ask questions.
- Support and praise a child for resisting peer pressure when it is not in the child's best interest, or for charting his or her own course of action.

To create a sense of *self-worth:*

- Deal with the event, not the child. Never let the child feel unworthy: "I think that you are a good ball player even if you didn't make the team—and you're a great guy!"
- Respect the child's likes and dislikes—let her choose her own clothing (within practical limits), for example.

To promote *self-efficacy:*

- Teach children that they have the power to change their behavior: "You used to come late for breakfast. Now you're always on time."

- Praise the child's strengths: "Valerie, that is a wonderful painting."

To help children learn to make *choices:*

- Negotiate with the child for the behavior you want, but don't lower your standards or negotiate from a sense of weakness. And don't ask a child to make a choice that should be yours. (Don't, for example, ask, "Would you like to go to bed now?")
- Give children a chance to choose what they do, wear and eat—but limit the range of choices you offer. Young children especially cannot handle a large number of choices.

To teach children *responsibility:*

- Hold the child to a course of responsible action: "You should have cleaned your room by noon. You can't go over to Bobby's now."
- Don't let children put blame on others or on events: "It is not the teacher's fault that the questions were hard. You are smart enough to answer them if you work harder and plan better. You would have felt good about yourself if you had worked harder."
- Expect children to take care of themselves—to make the bed, bring in the mail, shine their shoes.

To provide behavioral *standards:*

- Help the child to choose to adhere to your standards: "Mary, these are basic rules to live by. I live by them. You follow them and you will have a happier life."
- Announce standards for excellence in coping and being effective: "You really kept your cool when he got angry."

To create a calm and predictable *environment:*

- Arrange play areas for each child and keep noise levels low.
- Give children a feeling that they have control at home—that they have toys and clothes that are their very own.

To teach *self-discipline:*

- Don't nag. A rule should be something that is always followed: "You know the rule and I am not going to repeat it. You are able to do the right thing by yourself. Because you did not follow the rule, you can't go out and play."
- Try not to discipline in anger and lower the child's self-worth.
- Punish the child for the behavior.
- Expect the child to control himself.

Be a *model* for children:

- Clarify your own values and life directions. Define yourself—use "I" statements.
- Protect your own interests; don't get entangled in other people's problems.
- Be responsible, independent, self-disciplined, hopeful.
- Manage your life well. Act for yourself—do not be dependent on others.
- Enjoy life and keep growing.

"My Therapist Weighs 900 lbs."

by Lynn Gentry

Photos: Larry McSwain

Youngsters eagerly await their weekly appointments at the National Center for Therapeutic Riding. Opposite page: With the help of instructor Marty Leff, Destiny explores Dandy's back.

Spastic cerebral palsy has left Destiny's body very stiff, and she totters a bit trying to keep her balance while standing next to her therapist, who stands 13 hands tall on four legs and weighs 900 lbs. Her mother's hand steadies the 6-year-old girl as she extends her arm to offer her therapist her payment—an apple. Scenes like this—a handicapped or an emotionally disturbed child learning to love, trust and feel good about himself or herself—are everyday occurrences at the National Center for Therapeutic Riding in Washington, D.C.

Destiny's therapist is an 18-year-old female pony named Fine and Dandy (Dandy for short), who handles a caseload of 25 kids a week, and she's not just horsing around. Robert Douglas, owner of the Rock Creek Park Horse Centre in Washington, had a hard time getting people to believe in his program when he began the NCTR 12 years ago. But today the Center teaches riding to more than 500 emotionally, mentally and physically handicapped children every year. And there is a long waiting list of parents wanting to enter their children into the program.

"We are putting handicapped children in a setting in which they can do something their nonhandicapped peers may not do," Douglas says. "One boy came to the program dependent upon a walker, and at the program's end he was walking on his own. He even won a Special Olympic's track meet. I'm not saying miracles happen every day, but

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Lynn Gentry, an advertising and public relations major at Texas Christian University, Ft. Worth, Texas, served as an intern with the Children's Bureau, ACYF. Further information concerning the National Center for Therapeutic Riding and similar programs may be obtained from NCTR, P.O. Box 42501, Washington, D.C.

we have seen some dramatic turnarounds.

"Each day, I can watch something good growing in a child's life, a bigger smile, a stronger sense of self-worth, and even a new skill mastered."

In 1972, multiple sclerosis forced Douglas, 47, to quit his job at the National Institute of Health, where he was a research virologist. In a wheelchair and partially blind, he discovered that one desire had not left him: the desire to be active. He rediscovered his childhood love for horseback riding and began riding for therapy. Six months later, his sight returned and, amazingly enough, so did the use of his legs. He attributed his rehabilitation in part to riding—and Douglas figured if this worked for him, why not others?

Photo by David Doody/UNIPHOTO

Therapeutic riding programs were operating in Germany as far back as the 1600s, but only recently in the United States have people begun to notice the impressive results that can be attributed to such programs. Therapeutic riding programs are formulated with an emphasis on the development of educational and social skills as well as basic riding skills. Some of the major concepts and skills developed during the physical interaction between the child and the horse are in the following areas:

- body localization, as the child learns the horse's anatomy;
- body abstraction, as the child learns to relate parts of the horse's body to his or her own;
- muscular strength, as the child develops the ability to use his or her muscles while riding;
- health and hygiene, as the child learns to care for the horse;
- balance and rhythm, as the child learns to ride;
- directionality, as the child learns left from right;
- time orientation, as the child learns about feeding time, rest time and riding time; and
- anticipatory response, as the child learns how the horse reacts to commands.

Christina Rae Anfenson, a physical therapist who developed a therapy evaluation form for horseback riding, says that riding works well as therapy because it is dynamic treatment, rather than static.

The Center is run by Douglas and a small staff, which includes trained therapeutic riding instructors who adapt the riding lessons according to the needs of the children. The instructors use the horses for many kinds of educational and physical exercises, ranging from sit-ups on horseback, to deep breathing while the horse is cantering, to learning to follow instructions by the lead rider.

"With a horse, what you have, essentially, is a living and moving therapy table," Douglas points out. "Most physical therapists are lucky if they can get a child to cooperate and lift his hands above his head 10 times, or stretch his leg muscles. If you put a child in the stables, he will tiptoe to reach up and pet every horse in the stalls. Our instructors know how to make the horse into a useful therapy tool."

"It's amazing the reactions we get from kids once we turn therapy into recreation," Douglas notes. "Very few of the children want to miss their riding days, and the school teachers will find the children remember the riding day even if they have forgotten. I don't know too many therapists who can say kids are breaking down their doors, but therapists like Coffee Cake, Big Mac and Dancer can."

The program has been recognized by leading therapists and pediatricians and is considered a paraprofessional organization now because of its affiliation with the National Rehabilitation Hospital in Washington, D.C.

NCTR is not the only therapeutic riding center in the nation, but it is the largest one. It is different from other programs in that it is in an urban area, accessible to most of the special education children. Programs that are in rural areas have a much greater transportation problem.

The program began in 1973, when Douglas obtained funds from the Department of the Interior for a pilot project to provide specialized horseback riding lessons for students in special education classes in the Washington, D.C. public schools. These classes focused on the instructional techniques used in teaching physically handicapped, emotionally disturbed, learning disabled, hearing and visually impaired, mentally retarded and multihandicapped students, using the horse as a motivator. The school system agreed to supply the kids as long as the program cost them nothing.

After the first year, the D.C. School Board agreed to fund the program—the first such program to be fully funded by a school district. In 1980, it became a separate nonprofit organization known as NCTR, Inc.

The children who participate come from D.C. schools and the National Rehabilitation Hospital, and some are enrolled privately by parents. Classes are made up of 10 to 15 children of similar capabilities.

While the therapeutic results may be obvious, the educational benefits of the therapeutic riding program are equally impressive. Children are pre-tested for various educational skills and abilities and tested again at the end of the 8-week program. A study by the school district's Special Education Learning Center found improvement in almost every instance. For example:

- Children's listening skills and ability to follow instructions were up 80 percent.
- Interest in learning rose by 41 percent.
- Self-confidence was 62 percent higher.
- Physical orientation, or the ability to tell up from down, left to right and near from far, rose by about 60 percent.
- Vocalization and verbalization skills were up 93 percent.
- Seventy-six percent of the students retained and used their new vocabulary.
- Eighty-six percent began using whole sentences.

Douglas believes that the therapeutic riding program does what a number of therapists working with learning disabled children haven't been able to do: get the kids excited about learning. "Some of the kids can't learn enough about horses and animals once they get back into the classroom," he notes.

Some teachers ride with their students, and Douglas believes their involvement enhances the students' learning experience. "When students see their teacher riding with them, dealing with the same fears, it brings the teacher down from the pedestal and the kids can relate better to him or her," he explains.

In addition to providing physical therapy and teaching kids to ride, "we want to motivate children to learn and to not be afraid to try new things," Douglas says. "We use horses as positive vehicles for learning, and I think if we can get kids turned on to learning, we are making teachers' jobs easier."

Most of the work with the children is done by the six instructors, some of them show riders, who love horses—and who also love the opportunity to help the children discover new capabilities and to open up.

"Physically, riding is good because it involves three-dimensional movement—up and down, side-to-side, and front and back," explains Marty Leff, who has been an instructor for the past three years. "In a therapist's office children are asked to do three or four exercises to produce the movements and normalize muscle tone; horseback riding provides the same therapy in a non-threatening setting.

"For kids with neuromuscular disease or cerebral palsy, the earlier they can begin therapy, the better. It is possible to arrest some of the muscle deterioration before it gets too bad, and sometimes in cases where normal therapy may not do any good, horseback riding is great therapy.

"Psychologically," she continues, "horseback riding gets some of these kids ambulatory in a way they've never been before. The kids get to feel what it is like to move, and that might give some of them the mental drive to continue therapy towards the goal of walking on their own. When they are up on a horse they are moving faster and farther and more gracefully than they travel in their walker or wheelchair or with their braces.

"For some of them, this is the first time they've had the chance to control anything in their environment. I know we can't rejuvenate dead muscles, but we can help the kids to find new motor pathways, and learn to use them. Riding also stretches muscles these children might never use."

Photo : Larry McSwain

The horses give children a chance to develop trust and self-confidence.

Leff has found that the riding also produces dramatic results with children who are mentally and emotionally disabled. "The horses allow our groups a chance to develop trust and self-confidence, as well as the other skills we focus on," she says.

In addition to the instructors, Douglas is quick to praise the efforts of the Center's volunteers—some 100 persons ranging in age from 14 to 65, who contribute two to 20 hours a week working with the instructors. They walk alongside the horses, or help the children to saddle up. They are there to pat the kids on the back, and to reinforce the instructor's directions.

Mike Junge, a volunteer who has been with the program for four months, said the satisfaction usually comes in small packages, not dramatic miracles. "Some of the kids, when you wheel them up the ramp next to their horses, their faces just break out into smiles," he says. "You can't help but feel good."

Photo by David Doody/UNIPHOTO

A volunteer guides Dandy while Marty Leff helps Destiny perform exercises.

Some of the instructors worked as volunteers before they received their training at the Center in therapeutic riding. Some of the volunteers are college students who would like to enter the field later. Most are just people who've heard about the program on the radio or seen the facility when they've come to the park for rides. They all agree that the program has a special impact on the lives of the children who take part.

Another instructor, India Wright, enjoys watching the bond that forms between the children and the horses. She recalls working with one boy, who had been abused. She explains:

"At the beginning of the program he was obdurate and mean. He would hit the horses, and wasn't kind to his classmates, so he was alienated. He eventually learned to talk with his classmates and they learned to accept him. But most of all, he learned that violence was not the way to handle situations. He learned to pet the horse instead of hit it. That was probably the first chance he had ever had to relate to anything."

Wright remembers another emotionally disturbed child who was entering the program for the first time. "We usually start out the first couple of weeks doing ground exercises, letting the kids lead the ponies around and teaching them about grooming and horse care. We were at the outdoor arena one day, and he was having a really bad day. He said aloud, 'I hate living. I hate the world. I'm going to kill myself.' I let him have Knick Knack to lead around the ring, and when he came back 10 minutes later, he said, 'I love you and I'm so happy.'"

Douglas and the instructors are doing a lot more than just giving kids horses at the National Center for Therapeutic Riding. They are giving kids new hope, new laughter, new love, new lives, new dreams. And Douglas has bigger dreams for the Center, too. He would like to see an Olympic-size indoor arena, an expanded therapeutic program, new equipment and a larger staff to help more children.

"I have fantasies of a whole school built around riding for these children," Douglas says. "I already have evidence of how the program has helped over 4,000 kids with every kind of physical and emotional problem. I know the Center has played an important role in the educational lives of many youngsters. I think my dreams for the Center can come true."

Douglas isn't a quitter, that's for sure, and more and more people are paying attention to his program. They are watching children like Destiny sitting on horses like Dandy, and they are seeing changes in a child's life that are greater than just therapy. ■

Book Reviews

The Invisible Children: Child Prostitution in America, West Germany and Great Britain

Gitta Sereny (New York, Alfred A. Knopf, 254 pp., $17.95)

Children of the Night: A Study of Adolescent Prostitution

D. Kelly Weisberg (Lexington, Mass., Lexington Books, 298 pp., $27.00)

Reviewed by Michael Baizerman

The two books reviewed here exemplify the two main approaches to studying and understanding normal, troubled—and in-trouble—adolescents. One author uses a journalistic approach to understand the child and adolescent while the other uses classic social science methods to document and explain. One is oriented existentially and calls us to hear the cry of the children while the other presents us with the ordered rationality of factoids. One book is about children and adolescents working as prostitutes; the other is about juvenile prostitution (the word "adolescent" appears in the subtitle but not in the index).

Gitta Sereny is a European-born journalist now living in London. Her book presents case *stories* of adolescent males and females involved in prostitution in the United States, West Germany and England. Its greatest strength lies in the quiet rage of the biographies and the power of the youths' words as each talks about the current meaning of his or her life and personal history. A second strength is the cross-national and, hence, cross-cultural context of these stories: The similarities among

youths are more blatant than the differences of language, childrearing or client sexual preferences.

Another contribution is the author's self control in allowing these youths their own voice, undistorted. Yet this last strength contributes to a weakness: the author's restraint in generalizing, in pointing out commonalities across countries and youth. Her final sentences, however, show her ability to generalize and suggest our loss: "For victims they are: no child in prostitution *wants* to be a prostitute. They long to be wanted—as children. They long to be loved. They long to *be* children."

D. Kelly Weisberg, who holds a doctorate in sociology and a law degree, is Associate Professor of Law at Hastings College of Law, University of California, San Francisco. Her book is descriptive and analytic, with short case *histories* and empirical ethnographic and survey data presented as the base for discussions of law, programs and services. It presents an excellent outline of the subject, and is sensitive particularly to male-female comparisons, a needed perspective. Its limitation lies in the author's decision to study and report on adolescent prostitutes rather than on adolescents involved in prostitution and to write in scientific rhetoric. Its strengths are a good bibliography, a good introduction to the legal issues, and a good discussion of the criteria for community-based services.

Neither book uses an explicit adolescent or youth development model wherein developmental age supplants chronological age, and where age group behavior is a context for understanding the adolescents involved in prostitution. While Sereny reaches for the private and subgroup meanings of the life-events of working as a prostitute, neither author confronts, to my satisfaction, the related existential question: Are these youths "prostitutes"—to themselves, families, friends and others? Related are these common-sense questions: Are these adolescents troubled? And if so, are they beyond help? Could any one of these youths have been prevented from "the life?" Could the social institution of adolescent prostitution be controlled or prevented? Is early sexual, physical or emotional abuse a necessary antecedent to involvement in prostitution? Both authors provide partial answers to these orienting questions.

A youth services reader not familiar with the phenomena of adolescent prostitution should begin with Sereny because the adolescents' tears and joy are easy to touch; it is through such engagement that one can become angry and committed to action. Those familiar with the phenomena might begin with Weisberg's book and compare experiences to it as well as argue with its overly formal, partial and almost lifeless presentation and analysis.

Scholars, too, might follow the same reading sequence to appreciate again the need for a sensitive,

meaning-oriented social science treatment—a mix of these two books, which can be thought of as bookends on the subject.

Parents and adolescents should ready Sereny.

Michael Baizerman, Ph.D., is Professor, Center for Youth Development and Research, and Maternal and Child Health, School of Public Health, University of Minnesota.

Hawaii Is A Rainbow

Stephanie Feeney, photographs by Jeff Reese (Honolulu, University of Hawaii Press, $11.95)

Created to help children learn about colors and about Hawaii, this lovely book uses the colors of the rainbow as a way of organizing commentary and pictures of the many different people, places, plants and animals that make up the 50th state.

The first Hawaiians believed that when a rainbow appeared "it was a sign that something important was about to happen," writes author Stephanie Feeney. "Rainbows are still a very special part of life in Hawaii . . . and Hawaii is, in some ways, like a rainbow. The people . . . come from many places in the world, have skin, hair and eyes of different colors, speak many languages, and have different kinds of food, celebrations and art. Like the colors of the rainbow when people come together they seem even more beautiful."

The book design by Jill Chen Loui and the 62 color photographs by Jeff Reese capture this beauty and spirit. Adults and children alike will find much to appreciate in this very special book.

C.R.

The Child in the Family

Jay Belsky, Richard M. Lerner and Graham B. Spanier (Reading, Mass., Addison-Wesley Publishing Co., 276 pp., $14.95 paperback)

Reviewed by Milton F. Shore

This book is excellent for a number of reasons. It is developmental, stressing the changes physiologically and psychologically as the child grows.

It is multidimensional and interdisciplinary. The family is viewed from sociological as well as psychological perspectives.

It is ecological, stressing the interactions and reciprocity between the child's biological structures, temperament and needs and those of other members of the family.

It is empirically based, referring to data and our state of knowledge, citing a vast list of research studies, and critically assessing some current methodological problems as well as making suggestions for new directions in research.

Finally, the book is short, well organized, clearly written and available in paperback.

Structurally, the book is divided into two sections: one on children of different ages within the family context, and the other on five contemporary family issues—day care, child abuse, dual working parents, divorce and teenage pregnancy.

Two areas might have been expanded—there could have been greater detail on findings in dynamic motivational issues, and better explication of the cultural context and its relationship to the family and the child.

Nevertheless, despite these minor points, this book is a significant contribution to the field which brings us up-to-date on theory and research and their implications for practice.

Milton F. Shore, Ph.D., is a psychologist with the Mental Health Study Center, National Institute of Mental Health.

In the Interest of Children: Advocacy, Law Reform and Public Policy

Robert H. Mnookin (New York, W.H. Freeman and Co., 572 pp., $27.95 hardbound, $15.95 paperback)

Reviewed by Cecelia Sudia

This book is both fascinating and tedious. It is tedious because it is difficult to maintain concentrated attention over 572 pages of legal discussion, even though well written. But because it is sufficiently fascinating, challenging and tremendously enlightening, it holds that attention.

While really a textbook for a course on class action suits and legal advocacy, *In the Interest of Children* is also an intellectual and ethical inquiry into issues and values that are raised when the advocacy is on behalf of children.

All of the five law reform cases examined here were concerned with children, and all were eventually appealed to the Supreme Court. The cases reviewed and their eventual outcomes are as follows:

- Smith v. OFFER, a New York case requesting that foster parents receive a notice and the opportunity for a hearing before a foster child is removed. Foster parents were not granted any notice of due process by the Supreme Court, although the city of New York includes a modified version in their regulations.

• Bellotti v. Baird, a Massachusetts case to permit an unmarried pregnant minor to have an abortion without the consent of her parents. Such a minor can now receive permission for an abortion in a *pro forma* hearing before a judge.

• Halderman v. Pennhurst State School and Hospital, a Pennsylvania case that addresses the right of retarded children to receive education. The Pennhurst case is settled in principle—retarded children are entitled to family, community and education—but no one has yet solved the financial and other problems involved in achieving this end.

• Roe v. Norton, a Connecticut case requiring an unmarried mother to identify the father of her child in order that the government can proceed to collect child support payments. This case became moot when Federal Regulations affirmed that women can be required to provide information about their child's father with an exception allowed for "good cause" why she may not be so required.

• Goss v. Lopez, a Columbus, Ohio, case on the right of a school principal to arbitrarily suspend a student for misbehavior. Some measure of due process is now assured in the authority of secondary school administrators. About half of the states have subsequently enacted this provision into law.

Six contributing authors—Robert A. Burt, David L. Chambers, Michael S. Wald, Stephen D. Sugarman, Franklin E. Zimring and Rayman L. Solomon—present an extensive review of each case, beginning with the broader setting and including previous test cases, the issues in contention and, most important, the various factions and organizations involved.

A second chapter provides a step-by-step picture of the entire case, identifying all participants, providing background on the lawyers, the litigants, the judges and other interested parties. After discussing the judge's role and activities, Robert H. Mnookin suggests how a different course of action by the attorney or by the judge might have resulted in a different outcome.

For example, in the Pennhurst case there was considerable agreement that the school, as it was run, was not a good place for a retarded child. However, there was little agreement among parents, state education authorities, the state legislature and the court as to what the best solution would be. The judge issued an order that the school be closed and the children removed to community facilities. The number of children in the school was considerably reduced, but it was not closed. Could a different understanding, a different order, more publicity, more monitoring or persuasion have resulted in a different outcome?

However, the greater issues involve the determination of who is to decide what is best for the child or young person invoived. Is it in the child's interest for a mother to identify the father in order to get economic support or to make the child eligible for a number of possible benefits over his or her lifetime? What price is a mother expected to pay for this benefit? Physical harm? Personal notoriety?

Does a harassed judge, hearing a brief request from a teenager, adequately review that young woman's judgment that an abortion is in her best interests? Is this really better than allowing her to make the decision herself? Does due process in the child welfare system adequately protect the rights of children, parents and foster parents?

The issue of who speaks for the child and how they reach their decision is clearly unsettled. How is one to avoid the biases of one's age and position? To some degree, all factions in all cases argued that their view was in the best interests of children. However, there was very limited use of any research on children. Dr. Albert Solnit testified in two cases, and in Smith v. OFFER he was strongly contradicted by Dr. David Fanshel. Otherwise, research on children was not cited. Surveys of the available research literature might not have been compelling, but if one is representing the best interests of children, it is surely one source of unbiased information. Mnookin makes this point. He also raises a question about whether court decisions related to this issue offer very useful solutions. The main legal remedy, no matter what the problem, is to spell out due process. But what we really need are decisions of a better quality, not due process for more routine bureaucratic activity. What can help us achieve this?

Cecelia Sudia is Family Services Specialist, Children's Bureau, ACYF.

books in brief

Child Support: A Complete, Up-to-Date, Authoritative Guide to Collecting Child Support

In clear, readable language, author Marianne Takas—a lawyer and contributor to *Cosmopolitan, Working Mother* and other magazines—describes the legal and practical options available to help single parents obtain child support. In addition to discussing the Child Support Enforcement Amendments of 1984 and how the state Offices of Child Support Enforcement collect support, the book contains chapters on mediation, establishing paternity, getting a support order, documenting nonpayment and finding hidden income and assets. A list of resources is included, as well as a case information form.

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Stepping Out of Foster Care • Experiential Therapy for Youths

children today

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Children in Shelters

When women who have been beaten by their partners seek refuge in shelters for battered women, they usually bring their young children with them. Until recently, most shelters could offer only a temporary protected environment and some day care for children . . .

(continued on page 6)

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Cover photo by Allan Kaye/UNIPHOTO

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Special Report: Children In Shelters

6 Children in Shelters by Jean I. Layzer, Barbara D. Goodson and Christine deLange. In their study of children who come with their mothers to shelters for battered women, the authors found that nearly 70 percent were victims of abuse or neglect—yet only about 20 percent of the families were currently being seen by protective service agencies.

12 The Family Place Children's Therapeutic Program by Christine deLange. Although families live at a shelter for only a short time, therapeutic programs serve children at a very impressionable time and provide support and understanding regarding the changes in their family life.

16 Shelter-Based Parenting Services by Daniel T. Armstrong. Although facing seemingly overwhelming crises, the majority of women entering shelters express intense concern about the well-being of their children and welcome parenting program services.

21 Research with Children in Shelters: Implications for Clinical Services by Honore M. Hughes. Based on the research reviewed here on the effects of family violence on children, the author offers several recommendations for serving preschoolers and school-age children in shelters.

26 Experiential Therapy for Youths: The Adventure Model by Richard O. Kimball. Within the demanding context of the wilderness, troubled young people learn to take pride in their accomplishments, develop compassion toward others and assume responsibility for their own choices.

32 Stepping Out of Foster Care Into Independent Living by Eileen Mayers Pasztor, Jean Clarren, Elizabeth M. Timberlake and Linda Bayless. Based on their success with Project Stepping Out, the authors present a number of recommendations to help prepare older youths in foster care for emancipation.

36 Book Reviews: Silent Screams and Hidden Cries
Parents, Children and Change

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FYI / Worth Noting

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Adolescent Pregnancy. . . The Children's Defense Fund has launched the first phase of a 5-year national media campaign to prevent teenage pregnancy. Eight cities have been targeted for the first phase of the campaign, which consists of 30- and 60-second TV public service announcements and posters (like the ones reproduced below) on commuter buses and trains: Atlanta, Chicago, Detroit, Jacksonville, Kansas City, Minneapolis, Philadelphia and Washington, D.C. A range of materials will be developed, targeted to adults as well as teenage males and females.

CDF has also announced the creation of a new Adolescent Pregnancy Prevention Clearinghouse to provide information on community and policy activities designed to combat adolescent pregnancy. Among the materials currently available are *Preventing Children Having Children: What You Can Do*, a brochure for parents and community groups ($1.00); a companion policy agenda for federal and state public officials; and an 11-page report, *Adolescent Pregnancy: Whose Problem Is It?* ($2.50). For further information: Children's Defense Fund, 122 C St., N.W., Washington, D.C. 20001.

Last year 125,000 junior high students flunked this simple test.
HOME PREGNANCY TEST
Will your child learn to multiply before she learns to subtract?
The one on the left will finish high school before the one on the right.

FYI

Teens and Crime Prevention

Many adults are unaware that teens are disproportionately victims of crime, as well as victimizers. Once every 19 seconds, a teen in the United States is a victim of such crimes as robbery, assault, rape, larceny, purse-snatching and pocket-picking. In 1983 over 1.7 million crimes of violence and 3.6 million crimes of theft were committed against teens; one in four rape victims that year was a teenage girl and one in five assault victims was a teenage boy. While they represent only one-tenth of the population, persons 12 to 19 years of age are more frequent targets of crime than any other age group in the country—including adults and people over age 65. However, teens report crimes of theft and violence far less frequently than adults—for some crimes, less than half as often.

The National Crime Prevention Council has launched a national campaign in cooperation with the U.S. Department of Justice and the Advertising Council to make teens aware of their vulnerability to crime, arm them with knowledge to protect themselves and friends, and enlist their energies to build stronger, safer communities. The campaign encompasses the cooperative efforts of 103 national, state and federal organizations and agencies and stresses mass media public service advertising and technical assistance for local groups. It is directed to adults as well as teens, with information for criminal justice planners, youth workers, community service clubs, schools, libraries, public officials, administrators, police, foundation or corporate funders and parents.

As part of the campaign, the Council has published *Making A Difference: Young People in Community Crime Prevention*, a guide for communities and youth groups on youth participation in building safer communities. Funded by the Ford Foundation, the 132-page book identifies programs in which young people take an active role as integral and valued members of their communities: renovating housing projects, giving advice and guidance to younger children, organizing "block watches" in their schools and neighborhoods, teaching seniors crime prevention techniques and cleaning up graffiti in their neighborhoods.

Included are reports on 30 specific programs in the United States and Canada, with addresses, telephone numbers and names of contact persons. Many of the programs use teens as peer counselors, tutors and negotiators and are sponsored by law enforcement agencies, schools, youth centers and community groups. Programs also rely on such groups as local PTAs, churches, service groups, men's and women's clubs, small businesses and local government agencies for funding and other forms of support or involvement. For example, Teens on Patrol (TOPs) in Tampa, Florida—which operate through Chamber of Commerce support, local foundation funding and police supervision—places 16- to 19-year-olds in parks, recreation facilities, public swimming pools, Boys' and Girls' Clubs and retirement centers to assist in protecting persons and property and serve as role models for other youths. Positive Youth Action Teams in Waukesha, Wisconsin—funded by the Wisconsin Department of Social Services—work with schools, community associations, the YMCA, police and service groups to educate fifth and sixth graders about crime prevention in relation to vandalism, shoplifting and sexual assault.

John A. Calhoun, Executive Director of the National Crime Prevention Council, observes that teens are seldom given a stake in—or responsibility for—their communities. Instead, he says, they are viewed as "the source of problems, not as a neglected resource and a remarkable source of talent and creativity. Kids are reaching puberty earlier yet society says, 'We don't have a place for you until later.' So much goes into bottling the energy rather than using it to help enrich the community. Community crime prevention offers new vistas for permitting and encouraging young people in positive and valued contributions to their friends, families and communities."

Copies of *Making a Difference* are available at $10.00 each (discounts for bulk orders) from the National Crime Prevention Council, 733 15th St., N.W., Suite 540, Washington, D.C. 20005.

The Family and Education

Despite the research and common sense that point to the vital role of the family as educator, major education reports and education reform legislation have paid scant attention to its significance. A report released by the Home and School Institute, Inc., entitled *The Forgotten Factor in School Success—The Family,* examines research on the concept of family involvement and describes programs and cost-effective strategies that can be utilized by legislators, school board members and administrators to involve families in enhancing their children's education. The publication was produced with the support of the Field Foundation and the Yale University Bush Center in Child Development and Social Policy.

The Home and School Institute is a nonprofit educational organization in Washington, D.C. that works to link the resources of school, home and community to promote student academic achievement. The publication, an outgrowth of programs developed by HSI over the past two decades, uses demonstrated research to identify practical methods and policies that enhance the impact of schooling by involving the family. Pinpointing the family as a "major educational institution," the 72-page guide presents an analysis—along with answers and supporting details—for five major questions: what problems family involvement can solve; why family involvement is so crucial; what strong family involvement looks like; what schools can do; and what policymakers can do.

Dr. Dorothy Rich, author of the book and founder and president of HSI, writes: "Providing support for education without providing ways to involve families is a partial cure. It's like taking half a penicillin dose to cure an illness. It may start to work, but it won't be able to do the complete job. But of the 600 children and youth-related bills in state legislatures last year, most did not include measures to promote family involvement as a strategy to address educational issues."

The Forgotten Factor examines what students, teachers, parents and the public want from schools; discusses the growth of economically disparate parent groups; looks at what new directions government should take, highlighting action at the federal, state and local levels; and makes recommendations for action concerning programs and policies that affect the family, school and community. A checklist of 20 questions to help policymakers frame family-school initiatives is featured, along with a listing of additional resources and an appendix of sample home learning activities.

According to the report, two factors have contributed to the absence of family-related provisions in school reform legislation: The public is not aware of the research that points to the positive effects of family participation in education, and policymakers fear potential conflicts regarding the rights of government, parents and schools. Rich suggests that policymakers and parent groups launch information campaigns stressing the benefits of family involvement in schools, and she recommends that schools train teachers in methods of encouraging such involvement. She also cites activities developed by HSI for parents to use with their children at home.

Copies of the publication are available for $5.00 each from the Home and School Institute, Special Projects Office, 1201 16th St., N.W., Washington, D.C. 20036.

FYI/Resources

Upgrading Child Care Staff

Comparable Worth: Questions and Answers for Early Childhood Staff, a new publication from the Child Care Employee Project, describes successful attempts by child care advocates in using comparable worth as a job evaluation technique and educational strategy to upgrade salaries and status in the field.

In addition to defining the concept of comparable worth and reviewing the legal implications, the booklet explains how to collect wage gap information, analyze the setting and determine how a particular child care setting could best use comparable worth strategies.

Copies of the 22-page booklet may be obtained at $2.50 each (plus 50 cents postage) from the Child Care Employee Project, P.O. Box 5603, Berkeley, Calif. 94705.

Empowering Parents of Disabled Children

A non-traditional approach to helping families with developmentally disabled children, one that views parents as participants rather than patients or clients, is highlighted in *Empowering Parents of Disabled Children: A Family Exchange Center,* a handbook published by the Variety Pre-Schooler's Workshop, a private, nonprofit child advocacy organization.

Developed and prepared under a grant from the A. L. Mailman Family Foundation, Inc., the 28-page publication is a technical assistance manual designed for special education schools, mental health or parent organizations, religious groups, service clubs and others interested in establishing a Family Exchange Center (FEC) in their communities. The FEC model was created by Judith Simon Bloch, Director of the Variety Pre-Schooler's Workshop, as a mutual aid network offering group activities for families of children with developmental disabilities up to 16 years of age in special education classes. It provides a system of professional and peer support with social, recreational, educational, informational and respite activities. The manual covers the philosophical approach, implementation activities, program modules, potential pitfalls, suggested solutions to problems and staffing.

Bloch points out that the FEC represents an unconventional service delivery model that assumes its users are best able to identify and articulate their own needs and should share responsibility with professionals for developing and providing services to meet these needs. An FEC offers not only a program but also a place with at least one clearly designated and reserved clubroom or lounge that can adequately accommodate a few or a group, with or without children, both formally and informally. While location, program and activities may vary from setting to setting, all FECs share a basic rationale that recognizes the primacy of the family, the new presence of children with disabilities living at home, the importance of an interfamily mutual aid network, and the value of a system of linked professional and parent services with responsibility carried by both.

Requests from professionals for complimentary copies of *Empowering Parents of Disabled Children: A Family Exchange Center* should be made on organization stationery, signed by an officer/director, and sent to Administration, Variety Pre-Schooler's Workshop, 47 Humphrey Drive, Syosset, N.Y. 11791. Additional copies of the manual can be ordered for $5.50 each from the same address.

Preventing Stress

Jeffrey might as well have been a hungry lion as far as his mother is concerned. Her reactions would have been the same. But he isn't—Jeffrey is just her son. The name of the lion, it develops, is stress.

In *Making the World Safe for Jeffrey,* a 15-page, easy-reading booklet published by the National Committee for Prevention of Child Abuse, Jeffrey's mother, Vicki, writes to a friend telling her what she has learned about stress and how she can make it work for instead of against her.

Single copies of the publication are $2.00 each; prices for bulk copies may be obtained from NCPCA, Publications, 332 S. Michigan Ave., Suite 950, Chicago, Ill. 60604.

Child Abuse and Exploitation

The National Center for Missing and Exploited Children, a private, nonprofit advocacy organization created in 1984 through a cooperative agreement with the Office of Juvenile Justice and Delinquency Prevention, Department of Justice, publishes a variety of free informational materials that can help families protect their children against abduction, exploitation and abuse. The publications, designed for use by parents, support organizations, legislators, law-enforcement agencies and others dealing with cases of missing or exploited children, include:

• *Selected State Legislation,* which contains a sampling of state legislation from around the country and demonstrates how the issues of missing and exploited children are treated most effectively. Each of the 13 chapters examines a specific aspect of the problem of missing and exploited children: missing children; sexual abuse and exploitation; state criminal codes; courtroom procedures; privacy issues; education and

prevention; school programs; licensing and criminal histories; training programs for youth, social services, and criminal justice professionals; treatment and rehabilitation of child victims; court-appointed advocates; parental kidnapping; and child pornography and child prostitution.

• *Parental Kidnapping*, a handbook for parents, police, attorneys, prosecutors, family court judges and others who deal with cases of parental kidnapping, which includes an explanation of laws on parental abduction and practical information on measures that parents can take to prevent parental kidnapping.

• *Directory of Support Services and Resources for Missing and Exploited Children*, a listing of nonprofit or public organizations around the country that offer programs to help families and child victims of abduction and exploitation.

• *Child Protection*, a brochure that offers safety tips for parents and children.

• *Investigator's Guide to Missing Child Cases*, which is designed for law enforcement officers.

As mandated by the Missing Children's Assistance Act, the National Center for Missing and Exploited Children provides training assistance for law enforcement and child protection agencies in developing procedures to investigate and prosecute child victimization cases. The National Center also assists individuals, groups and state and local governments involved in prosecuting cases of criminally or sexually exploited children; offers prevention and education programs for parents, schools and community and volunteer organizations; conducts an outreach program to alert families, communities and the criminal justice system about the extent of child victimization; and distributes photos and descriptions of missing children nationwide. A toll-free telephone line (1-800-843-5678) is available for those who have information that could lead to the location and recovery of a missing child.

Further information on the National Center's publications and activities can be obtained from the National Center for Missing and Exploited Children, 1835 K St., N.W., Suite 700, Washington, D.C. 20006.

Neonatal Loss

Helping parents who have experienced a neonatal loss—including a miscarriage, a stillborn birth or sudden infant death—to cope with and resolve feelings of grief, anger, guilt and despair is the focus of *Feelings*, a booklet developed by the Cleveland Regional Perinatal Network, a program of MacDonald Hospital for Women, University Hospitals of Cleveland and Cleveland Metropolitan General, and Highland View Hospital. Funded by the Ohio Department of Health, Division of Maternal and Child Health, the publication is designed to foster the use of a support system and to facilitate communication among caregivers and extended family members.

Written in clear, simple, conversational language that uses the second person pronoun to reinforce its personal style, the booklet discusses the sense of bereavement, anguish, frustration and helplessness common to parents, brothers, sisters and grandparents after the loss of an infant. Reactions of friends to hearing about the baby's death—ranging from discomfort to avoidance or minimizing of the topic—are described, along with the different stages of mourning experienced by parents during the healing process.

Characteristic responses of family members include memories or thoughts of the dead infant or of previous losses, marital tensions, social isolation, crying spells, insomnia, loss of appetite, nightmares, feelings of failure and loneliness and fatigue, as well as the need to express the pain of the loss through verbalization or writing. During the grieving process, many seek solace and a sense of purpose, direction or control in religion, while others become angry and confused about beliefs they previously held. The booklet stresses that for all who have experienced a neonatal loss, the final stages of the healing process involve an understanding of the feelings experienced during grief, an acceptance of the baby's death and, finally, an affirmation of life.

Copies of the 20-page booklet are $1.50 each and can be ordered by contacting Feelings, Cleveland Regional Perinatal Network, MacDonald Hospital for Women, Room 350, 2105 Adelbert Rd., Cleveland, Ohio 44106.

Letters Welcome

We want to hear from you! Readers are encouraged to submit comments . . . reactions . . . opinions . . . about articles in the magazine and/or issues affecting children, youth and families today. Please send to Editor, CHILDREN TODAY, OHDS Office of Public Affairs, 200 Independence Ave., S.W., Rm. 356-G, Washington, D.C. 20201.

(continued from cover) . . . their mothers were perceived as those in need of counseling and therapy. In recent years, however, concern about the long-term effects on children of living with and witnessing violence, together with evidence that many children are themselves victims of abuse, suggest the need for remedial and preventive services to help break the cycle of family violence.

In 1981, the National Center on Child Abuse and Neglect (NCCAN) funded six demonstration projects designed to modify the effects of violence on children through crisis intervention and remedial activities; to identify needed community services and act as advocates for this population; and to develop techniques to improve parenting skills in violent families. Five of the projects continued after the initial funding year: Child, Inc., Wilmington, Del.; Project for Victims of Family Violence, Fayetteville, Ark.; Harper House, Davis, Calif.; Council on Battered Women, Atlanta, Ga.; and The Family Place, Dallas, Tex.

The Family Place was selected to provide technical assistance to the demonstration projects and to oversee the collaborative research. As part of its research mandate, The Family Place contracted for a study

Group work organized around a craft activity helps children identify behaviors and learn to cooperate.

Children in Shelters

by Jean I. Layton, Barbara D. Goodson and Christine duLaney

Photos: Allan Kaye/UNIPHOTO

of the children who came to the shelters. This article summarizes the findings of that research and offers recommendations to improve services for victims of family violence.

Data Collection

The five shelters were asked to complete assessment forms on each child who came to the shelters during a specified time period. Assessment forms were completed for 906 children, and forms describing such characteristics as income and family problems were also completed for each family in the shelter. A third source of data was a follow-up form, added after the evaluation project started. Follow-up data were collected in a less systematic way. Shelters tried to follow as many children as possible, but since only the Dallas project was funded to provide follow-up services to women and children who left the shelter, that project was able to collect follow-up data on more children—44—than the other projects. Follow-up data were received for a total of 112 children.

Major Findings

The women and children who came to the shelters left homes in which physical violence and emotional abuse were frequent and had persisted over several years. A few violent incidents were not sufficient to drive these mothers from their homes; close to half of them had been battered for more than five years, weekly or more frequently. For some of the women, battering was a daily occurrence.

Children in these homes both witnessed violence when it was directed at their mothers and were themselves victims of it. Nearly 70 percent of the children who came to the shelters were victims of abuse or neglect. Nearly half were physically or sexually abused; in addition,

most of these children were emotionally abused and physically neglected. Physical attacks on children were often savage—guns, knives, poison and burns were the weapons used on half of those who were physically abused. Five percent of the children had been hospitalized as a result of the abuse.

The batterer of the mother was usually the abuser of her children, although, in about one-quarter of the cases, the mother joined the batterer in abusing the child. In a few instances, only the mother was the abuser.

Violence directed at children was rarely a recent or new event. In the case of emotional abuse, neglect and physical abuse, more than half of the children had been victims for at least a year, and more than 20 percent of the children in each group had been abused or neglected for more than three years. In the case of sexual abuse, most of the abuse was identified as recent—occurring within the year—and for 20 percent of the children it was judged to be one incident only.

Despite the pervasiveness of the violence towards children, only about 20 percent of the families were currently being seen by protective service agencies. This group of children who entered shelters with their mothers represents a population of abused and neglected children largely unknown to and unserved by the agencies mandated to protect them.

Jean I. Layzer and Barbara D. Goodson, Senior Research Analysts with Apt Associates, served as consulting researchers to the NCCAN domestic violence demonstration projects. Christine deLange, a Washington, D.C. area-based consultant on child abuse and family violence and a Board Member of Virginians Against Domestic Violence, was formerly Associate Executive Director of The Family Place, Dallas, Texas.

Most of the women who come to shelters are married with two or three children.

The Mothers

Most of the women who came to the shelters with their children were between the ages of 20 and 35, married, with two or three children. Just over half were white, a third were black and nearly 10 percent, Hispanic. They had little formal education—most had not graduated from high school—and the majority were unemployed or had never worked.

Many of the mothers were poor. The family incomes for more than half of them were less than $8,000 a year, below the poverty level for a family of four. About 15 percent of the mothers had annual family incomes of at least $16,000.

Among the married women, 85 percent had been living with their husbands before they came to the shelter. Of the unmarried women, just over half were living with a man.

Family Stresses

Families suffered from multiple stresses and problems. In addition to being poor, the women were socially isolated and had heavy child care responsibilities. Many (more than 40 percent) of the batterers had problems with drug and alcohol dependency, and most had mental health problems. About a fifth of the families had previous court or prison involvement, and nearly half had previous contact with social services agencies.

The Children

When the women came to the shelter, they usually brought all of their children with them. Most of

Photos: Allan Kaye/UNIPHOTO

A structured, predictable daily schedule of activities is an important element of shelter therapeutic programs.

the children who were left behind with relatives were older, often teenagers. The majority of the mothers brought in a preschool-age child. Nearly half brought in an infant and half a school-age child. The children brought to the shelters were the natural children of the mothers; most were also the natural children of the batterer. About 17 percent were stepchildren of the batterer.

Although few of the children had chronic mental or physical health problems or problems surrounding their births, many of the children exhibited health and behavior problems that seemed likely to be related to their violent environment. The children who were known to be abused or neglected had higher incidences of all of the problems.

Among the infants, more than half had health problems. Weight and eating problems were identified in almost 15 percent of the infants, and nearly 20 percent suffered from sleep problems and problems in responsiveness. All of the problems were noted more frequently in infants who had been abused in their homes.

Among children older than 18 months, nearly 70 percent exhibited mood problems such as anxiousness, crying and sadness. About 40 percent had problems interacting with other children or adults. More than a third had health problems and sleep disturbances. Like the infants, all of these children's problems were more frequent among children who had been abused or neglected.

Services Provided

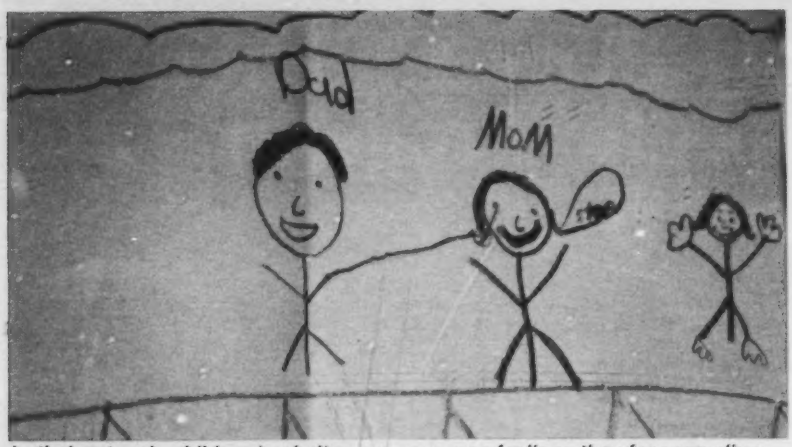
All of the projects developed programs to address the needs of children from violent homes. Although the shelters used similar intervention techniques, each had some aspect of service delivery that differed from those of other projects.

All provided a structured daily activity program for resident children with some variation in hours/days and days/week. A major activity was group counseling sessions for school-age children. For preschoolers, programming varied in format and focus. At The Family Place, for example, preschoolers were involved in group work organized around an art or craft activity designed to teach the identification of feelings, cooperation and nonviolent methods of need attainment and gratification.

Parent education or education in family life skills was a component of all the projects, and because of the short lengths of stay for families in a shelter environment, advocacy services were provided by each of the children's programs. Community mental health agencies, recreation groups, out-patient clinics and various family counseling services were identified and collaborative relationships developed. In each

At The Family Place in Dallas, Children's Counselor Mack Hazley helps children develop healthy alternatives to dealing with frustration and anger.

Photos: Allan Kaye/UNIPHOTO



In their artwork, children in shelters may express feelings they fear revealing even to themselves.

project, child advocates worked with CPS staff to insure coordination of services to shelter clients.

Follow-Up Findings

Although the evaluation was not intended to assess the effects of the shelters' services on the children, the shelters did collect limited follow-up data on some of the mothers and children. However, these findings must be treated cautiously, since it is unclear to what extent they can be generalized.

In this sample, the major factor determining whether violence continued in the children's lives was the mother's decision whether or not to return to live with the batterer. In about half the families, the batterer was not living in the home at the time of follow-up. In almost all cases where children were no longer living with the batterer, they ceased to be the objects of physical violence. In the majority of cases where children continued to live with the batterer, they and their mothers continued to be abused.

We looked in more detail at data from the Dallas shelter, which was the only one to offer follow-up services. Since the follow-up program was offered only to women who had left the batterer, all 44 children in the sample were no longer living with the batterer. Dallas staff found that all but two of the 15 children who were being abused or neglected when they came to the shelter were no longer being abused or neglected at the time of follow-up. These included children who originally had been abused or neglected by both the mother and the batterer as well as children who had been abused or neglected by the batterer alone. Only the two children were still being abused; both were children who had been physically abused by their mother and the batterer before their mother came to the shelter. In most cases, removing the batterer from the home ended the abuse of the child. Only one of the women reported any continuation of the spouse abuse, and here the level of violence was lessened.

More than half of the children had no contact with the batterer. The other children had contacts with the batterer ranging in frequency from weekly (22 percent) to monthly or less (22 percent).

There were costs to the family occasioned by the batterer's absence from the home: Forty percent of the mothers reported a drop in family income as a consequence.

Recommendations

Based on our research with battered women and children, we offer the following recommendations to child welfare workers, administrators and policymakers.

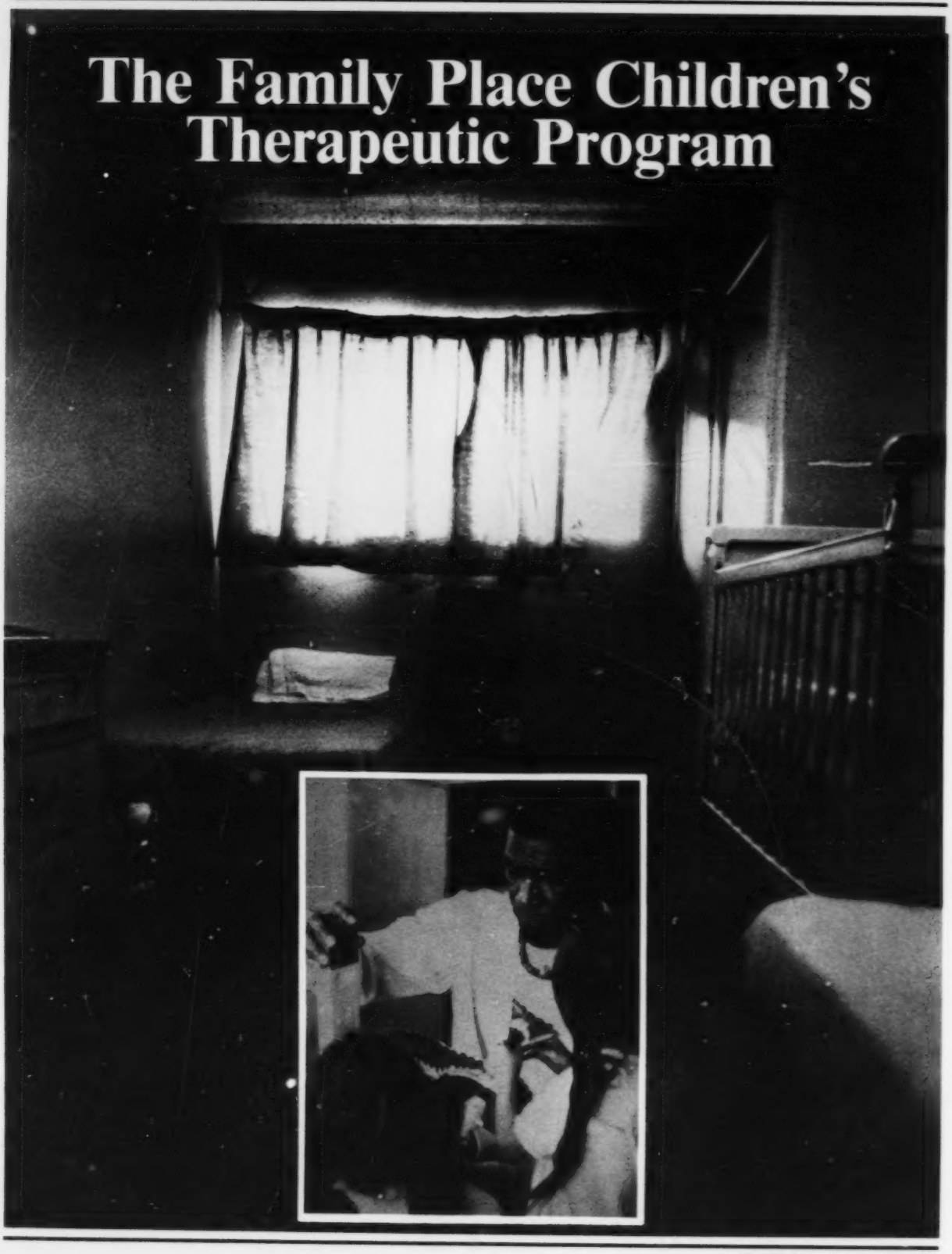
- As we noted earlier, only 20 percent of the families were seen by protective agencies, in spite of the widespread prevalence of abuse and neglect in these families. Clearly, this indicates that *stronger linkages need to be established between CPS workers and shelters for battered women.* CPS workers need more training in the distinctive dynamics of spousal violence, and shelter workers need to be aware of the community agencies and services available to assist child victims.

- Earlier studies of programs for abused children have shown that only a minority receive any kind of medical screening. This was true for children in these shelters, even though they exhibited a variety of physical and behavioral problems. Thus, *all children in shelters should have access to medical screening and treatment.*

- The longer families stayed in shelters, the more likely workers were to identify sexual abuse problems. *Shelter staff need training in the identification and treatment of sexual abuse,* perhaps through linkage with sexual abuse treatment programs, and shelters need help in developing sexual abuse prevention programs for children while they are in the shelter.

- Finally, *women who leave shelters with their children need ongoing support to help them maintain a nonviolent environment for their children.* Parent aide programs and other ex-residents' programs could help to provide the support systems these women need. Much of the effort expended by shelter staff will be wasted if there is no attempt to follow up and support families after they leave the shelters. ■

The Family Place Children's Therapeutic Program



Photos: Allan Kaye/UNIPHOTO

by Christine deLange

Opposite page: A family's room at The Family Place—formerly a small private hospital. Insert: Children's Counselor Mack Hazley provides children with a strong yet nurturing role model. Above: Carol Chism, Executive Program Director of The Family Place, listens thoughtfully to a client.

The Family Place recognized, early on, that children from violent families were themselves traumatized, often abused, emotionally neglected and suffering from severe mood swings brought on from living in the stress and tension of violent family relationships. Records kept by The Family Place documented that of the children who came to the shelter, 55 percent were victims of physical abuse and 12 percent experienced sexual abuse. In addition, 75 to 80 percent displayed social and emotional problems—nightmares, bedwetting, tantrums, biting, kicking, excessive anger and fear. These statistics continue to be validated by ongoing recordkeeping and staff observations of the children.

Behaviorally, the children who come to the shelter exhibit low self-esteem, lack of impulse control, short attention span and an inability to control anger. While some children are often physically aggressive and verbally abusive toward other children and adults, others display passive and withdrawn behavior. These children are often pseudo-mature and take on adult responsibilities in the family, such as tending babies, housecleaning and parenting younger siblings. These children are often socially isolated from their peers and do not relate to the activities or interests of their age group. This role reversal results in the loss of valuable developmental time, which affects the child's future maturation and preparation for adulthood.

The children's Therapeutic Activity Program at The Family Place is designed to interrupt this distorted process and provide children with positive role models and experiences that build self-esteem and develop healthy alternatives to dealing with frustration and anger. The program has three major components: crisis intervention activities, remedial activities and advocacy services. Program activities take place Monday through Friday from 10:00 a.m. until 6:00 p.m., as well as four evenings a week. Field trips and special events, conducted by community service groups and/or volunteer assistants, are planned for weekends.

Crisis Intervention Activities

If the shelter environment is to be a positive experience for a child, then immediate activities must be engaged to make the child as welcome and comfortable as possible upon entering the environment. Staff members assist children in this transition by introducing them to the play areas and to the other children in residence.

Soon after entering the shelter, mothers are also interviewed by a children's staff member to provide her with emotional support and counseling with regard to her children. Later, after the family has become acquainted with the environment, information is gathered to assess the child's developmental, psychosocial and immediate health, welfare and schooling needs.

The goals here are to decrease any possible frustration or stress on the mother's part related to her children's behavior, provide her information and insight into the possible effects that this change in family living may have on her children, and let her know that the children's staff is there to assist her in any parenting problems she may encounter.

Remedial Activities

Remedial activities in the children's therapeutic program need to stress two major elements significant to working effectively with this population: a structured, consistent, predictable daily schedule of activities, and therapy/counseling activi-

Christine deLange, formerly Associate Executive Director of The Family Place, is a Washington, D.C. area-based consultant on child abuse and family violence and a Board Member of Virginians Against Domestic Violence.

ties in which each child or group of children can disclose feelings and act out needs.

Daily Program

Both school-age and preschool children participate in activities planned and implemented to enhance self-esteem, stimulate problem solving and creative play, improve socialization skills, increase coping mechanisms to better handle anger and frustration and teach more appropriate ways to gratify needs. (These behaviors, which have been pinpointed by researchers as problem areas for abused children, have been observed by The Family Place staff as issues for children from violent homes.)

Children of school age are enrolled in the local schools within two to three days after entering the shelter. This is considered a necessary adjustment time. In the daily program for preschoolers, which is conducted between 10:00 a.m. and 2:30 p.m., children's counselors plan arts and crafts, music, games and other activities designed to enhance self-concept (making a book about the child and naming body parts, for example) and facilitate predictability and consistency with the child's daily routine.

Therapy/Counseling

Both individual and group therapy are provided. The individual play therapy or "special time" experience serves to establish for the child a trusting relationship with a particular adult, something which these children have generally not experienced as a result of explosive, unpredictable family relationships. (The term "special time" is used to define the experience as one of support and relationship-building and should not be confused with what is traditionally known as play therapy.)

Group therapy is primarily conducted with children age nine and older. However, younger children age six to eight appear to respond well to activity groups where a therapeutic milieu is maintained to assist them in cooperative play, needs gratification and development of positive self-image and peer relationships. Groups for older children explore such issues as trust, fear, anger, needs attainment and friendships/relationships.

Parent-Child Program

Intervention focused on parent-child interactions is a significant part of the children's program. Both formal and informal interventions take place daily between staff and mothers. The goal is to decrease stress and destructive patterns of interactions and communication between mother and child. Parent-child activities are planned and implemented by the children's counselors one afternoon and two eve-

Photos: Allan Kaye/UNIPHOTO

nings a week. Direct participation sessions provide parents an opportunity to learn and practice new and positive interaction styles with their children while staff members model appropriate discipline techniques and child care methods and reinforce the parents' positive behaviors. Activities are specifically selected so that parents can learn to do enjoyable things with their children—play games, go on outings, make craft items, for example—while they also learn to perform caretaking and discipline tasks with less anxiety and ambivalence.

Now that the batterer is no longer in overwhelming control of the family, the mother and child often need assistance in negotiating their relationship. For those women and children needing additional counseling, individual meetings or family sessions are set up with staff members and/or trained volunteer assistants to provide the family the necessary interventions as well as support and understanding to restructure ineffective patterns.

Advocacy Services

Children in residence at The Family Place are assisted in receiving from the community those services identified by both the staff and parent as important to the child's health, welfare and educational and psychological well-being.

Referrals are made on behalf of the child by a children's counselor or by the child's mother, with assistance from staff when necessary. In addition, a staff member monitors progress on referral contacts, records them in the child's file and follows up as appropriate to insure contact is made.

The Family Place also maintains a close working relationship with Child Protective Services. Reports are made on suspected abuse and neglect cases either by a staff member or by the woman herself, if the father is identified by her as abusing the child(ren). CPS workers often interview families at the shelter, and shelter staff often act as the primary liaison while the family remains in the shelter. When the family leaves, staff members contact the CPS worker to report the family's new living arrangements and to further advise workers as to the child's well-being.

Conclusion

Although families live at a shelter for only a short time, shelter programs serve children of battered women at a very impressionable time. The mother is taking control after a violent episode and suggesting to her children by her actions that being beaten isn't the only way to live. Therapeutic programs for children entering a shelter at this time have a unique opportunity to intervene in the child's world and provide support and understanding regarding the changes in their family life. Shelter programs have an opportunity to identify and assess each child's special needs and assist in remediating social-emotional problems through direct intervention and advocacy service. ■

Shelter-Based Parenting Services:
A Skill-Building Process

by Daniel T. Armstrong

Parenting, a life role that most of us assume with little or no formal preparation, can be demanding, even when the partners have a stable and mutually supportive relationship, financial stability and experiences that promote self-confidence and self-esteem.

Most adults who seek the safety of battered women's shelters are not experiencing such favorable conditions. Their lives are in turmoil. They are often fleeing, at least temporarily, relationships that have contributed to lowered self-confidence, confusion and pain. They must decide whether they want to, or can, return to their partner—and if so, under what conditions, or if not, how to face the uncertainty of starting over. Housing, medical attention, legal action, child custody, employment/income, child care, visitation, transportation—all are among the issues that must be faced within days of coming to a battered women's shelter. Given these seemingly overwhelming concerns, one might ask whether it is necessary to conduct a parenting program at this time of crisis, and whether it is realistic to hope that such a program will have a significant impact on participants when it must vie with so many other "crises" issues.

In considering these questions, it is important to keep in mind that children entering battered women's shelters have a special need for an

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Holly Grafton discusses the results of a developmental screening test with a program participant (above) while Yvonne Nass listens to a question posed during a shelter group meeting.

Photo: Holly Grafton

effective and caring parent figure—a role that their mothers may not be prepared to fill at the time of admittance. Indications are that about a third of the women entering shelters were raised in families where they and/or other family members were victims of abuse and hence may lack adequate parental role models. In addition, a small but significant percentage of women entering shelters are themselves perpetrators of child abuse and neglect. Moreover, we have found that while the majority of women in shelters whose children have been abused or neglected initially object to the degree of violence that has been inflicted upon the children, they do not reject the concept of violence as a means of discipline and control.

We have also found, however, that a woman's commitment toward the well-being of her children is often a major factor in her decision to come to a shelter, and many women express the desire to help their children overcome any damaging effects of having lived in a violent and chaotic home.

Taken together, these findings support both the need for shelter-based parenting services and the belief that such services, if presented in a timely and sensitive manner, will be welcomed by the majority of women who seek the safety of a shelter.

The Shelter Parenting Program offered by CHILD, Inc.* at the New Castle County (Delaware) Battered Women's Shelter is a cooperative effort of two pre-existing CHILD, Inc. services. One, the Parent Education Program, is an 18-hour course offered tuition free throughout Delaware at selected community sites. Originally funded in 1978 by the National Center on Child Abuse and Neglect (NCCAN), the project is currently funded primarily by the State Department of Services to Children, Youth and Their Families. The other service is the Children's Program—a part of CHILD, Inc.'s Family Violence Program—which offers assessment, referral and counseling services for children at the shelter. This project, also originally funded by NCCAN (in 1981), is currently supported by the State Department of Justice.

The Shelter Parenting Program shares the overall goal of the Children's Program, which is to break the intergenerational cycle of violence so often seen in families experiencing either child or consort abuse. The parenting program attempts to do this by combining an instructional group format, in which information on skills essential to parenting is presented to and discussed by participants, with a series of individual and/or family sessions, in which participants are helped to apply these skills to specific situations. The shelter's "No-Hitting" rule, which prohibits all physically violent interaction including that used in parent-child discipline, makes learning new methods of parent-child interaction even more essential. The program is conducted by the group leader, Yvonne Nass, and the child therapist, Holly Grafton, both experienced counselors and parent educators, who have conducted the Shelter Parenting Program since its inception in 1981.

The formal curriculum, which is presented at the shelter in five weekly sessions, each two hours in length, is designed both to provide new information and to reinforce important concepts participants may already know. It focuses on increasing the mothers' competence in several areas: interpersonal skills (communication); self-control (through the introduction of stress management techniques); empathy (through understanding developmental issues and learning to view situations from a child's perspective); parenting skills (through the introduction of practical guidelines on discipline and supervision); and relationship building (through learning the language of encouragement as well as how to "enjoy" time spent with one's children).

The group format used for the instruction also serves other important functions—it allows for support and acceptance of each participant, and it provides an opportunity to share ideas and "help" other group members.

Some group members initially have trouble expressing themselves, due in part to fear over how other members will respond, while others have never had the experience of being listened to with interest and respect. Thus, it is often necessary for Yvonne to model how to share personal information, concerns and interests.

Yvonne notes that sensitivity to the frustrations of motherhood enables her to identify emotionally with the mothers. "Once I start sharing my own feelings, they seem able to relax and share some of theirs," she explains. "Some want to talk, some want to listen, all want to explore ways of helping their children feel better about themselves. The skills are never discussed in terms of the 'right' way or the 'wrong' way. Instead, they are discussed in terms of what is an effective way to parent our children."

While the group process offers the mothers an opportunity to share information and experience personal acceptance, it is within the individual and family component that they have the most opportunity to relate what they are learning about parenting to individual situations. To help a mother work on specific parenting issues, Holly suggests following several interrelated steps:

• Ask the mother to list her most crucial concerns regarding her child's behavior—temper tantrums, sleep disturbances or eating prob-

Yvonne conducts a Parent Education Program at a community site.

lems, for example.

- Determine what methods the mother has used in attempting to modify the "problem" behavior and what the results have been: "Are you telling me that when your son has a tantrum and you yell at him, he gets worse?"
- Decide, with the mother, which method(s) will now be attempted to help extinguish the child's undesirable behavior by first asking, "What could you do when your son has a tantrum?" and "How could that be done?" If no ideas are forthcoming, suggest a course of action: "Other people I know have dealt with tantrums by ignoring the behavior or trying a 'time out.' What do you think would happen if you were to try one of these methods?"
- Help the mother to anticipate what might go wrong and how to handle those possibilities: "What if you decide to ignore the tantrum and another resident yells, 'Can't you make him shut up?' "
- Identify possible motives underlying the "problem" behavior and determine a constructive way to meet the need expressed by those motives: "If his tantrums are a way of seeking your attention, how could he ask you to pay attention in a way that you would consider acceptable?"
- Evaluate the success of the methods chosen in producing the desired change: "How many tantrums has he had?" "Are they as severe?" "Has he asked for attention in other ways?" "What happened when he did?"
- Finally, provide reinforcement for follow-through by the mother: "Wow! It sounds like you really held to your position and at the same time didn't get angry and lose control."

Why does this process so often prove effective? Holly comments:

"When a mother starts this process, she is often feeling frustrated, inadequate and out of control both towards herself and her child. She's frequently hoping for a 'magic' formula or technique that will clear up the problem behavior. What I think happens much of the time is that once a plan has been established, agreed upon and practiced, the mother begins to feel reassured that she is not totally helpless or inadequate in the face of the problem. When this realization comes, she now feels more in control of herself and can relax some. Being able to relax, in turn, increases her level of tolerance, making her less likely to fall into old traps in trying to deal with the 'problem' behavior. Faced with a mother who is more relaxed and consistent in her manner of responding, the child is, in turn, less anxious and has less need to act out. Finally, as the child's behavior improves, the mother feels less frustrated and resentful and is more willing to relate to that child in a positive and encouraging manner."

The following case examples illustrate how the program operates.

Ann

Ann, the 19-year-old mother of one child, told Holly, "If it weren't for Robbie I'd still be there—if it had been only me he beat instead of Robbie, I'd probably go back now." Robbie, her 3-year-old son, sat near her with strap marks still across his face, bloody marks on his ears and black-and-blue bruises on his back from a belt wielded by Ann's boyfriend, Tom.

Robbie had awakened in the morning and poured juice for himself. In the process he spilled much of the carton, which he attempted to clean up, throwing the carton in the trash. Upon finding the carton, Tom became enraged that Robbie had "sneakingly cleaned up" and had tried to hide the carton, so he "taught him a lesson." Ann agreed Robbie had it coming—he was bad and should be whipped. But this time Robbie was really hurt. She

Photo: Holly Grafton

became angry at Tom for overdoing it. Ann took Robbie to a doctor, who called Child Protective Services. Then, afraid to return home, Ann called the shelter and was admitted on June 18.

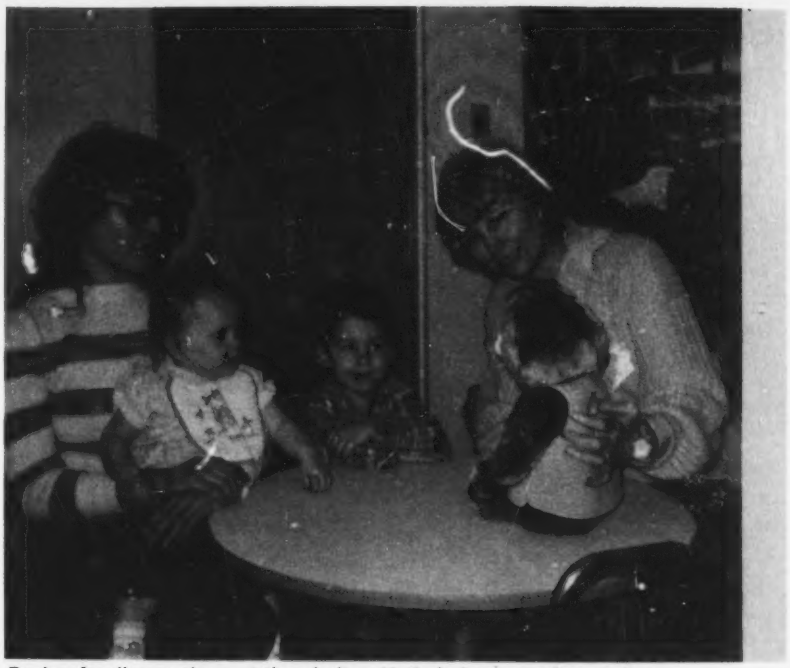
Robbie was out of control and acting out aggressively. Ann knew only to threaten and spank, which only increased his anxious and aggressive behavior. It became evident that her ideas of reasonable expectations for a 3-year-old were very unrealistic. Ann's conclusion was that Robbie was a bad kid and did these things to "get" her.

Where had Ann learned to parent? Her model for parenting came from a severely abusive family and a series of short-term foster care placements. At age 18, with a 2-year-old child, Ann moved from foster care to an abusive and violent relationship with Tom.

Given Robbie's behavior and Ann's lack of knowledge about nonviolent discipline techniques, individual counseling with Holly was started immediately. Since Ann was unable to visualize alternatives to spanking, Holly told her about time-out procedures and helped her to see how she could use these in responding to Robbie. Ann practiced the procedures and, almost immediately, she experienced some degree of success.

This success was important to Ann. Nearly six months later, on a return visit to the shelter, she recalled: "Robbie didn't change much at first, in fact he might have gotten worse, but I felt better because at least when he started and I could feel everyone in the house ready to get on me, I had something that I could do."

Once Ann started attending the group sessions with Yvonne, she would often point out to Holly similarities in the group material with what she and Holly were working on together—an encouraging sign regarding her ability to generalize the more positive responses that she was learning.



During family sessions at the shelter, Holly helps a mother work on specific parenting issues.

Within three weeks of her admission to the shelter, Ann was able to "guess" that Robbie was often scared, uncertain and out of control, and she was able to talk to him in a caring manner about these feelings. While the content of Ann's message may or may not have had its desired impact on Robbie, the caring tone of that message, repeated often, almost certainly did. As Ann's empathy toward Robbie increased, positive interactions between them became more frequent and Robbie's aggressive acting out decreased dramatically. When it did occur, Ann still had the time out to fall back on.

Seven months have passed since Ann and Robbie were admitted to the shelter. They are currently sharing an apartment with another ex-shelter resident (no other children). Ann is enrolled in a job skills program and Robbie is making a fair adjustment to day care. Ann is also working on parenting skills with a CHILD, Inc. Home Visitor, a parent aide who works with Ann in further developing her parenting skills and relationship with Robbie. She continues to feel positive about the changes in her relationship with Robbie.

Looking back on their pre-shelter relationship, Ann reflects: "It scares me . . . I'm not sure we would have both survived it. I don't think that I would really have hurt him but you just don't know."

Helen

A situation does not have to be as severe as Ann's and Robbie's for the shelter parenting services to be useful.

Helen came to the shelter in January, following an incident in which her husband, Stan, had grabbed and begun to choke her. Although not physically injured, Helen was fear-

ful of what could have happened and was hurt by the verbal abuse that both accompanied and occurred in between the occasional physical assaults. The couple's two children, Adam, age four, and Michelle, age two, were not victims of abuse or neglect. (Neither Helen nor Stan believed that hitting children was acceptable.) The children were age appropriate or beyond in their development and did not act out excessively after their admittance to the shelter. Helen believed that what problems she had in dealing with them occurred for the most part when she felt pressure due to Stan's behavior. As Helen explains:

"When Stan was getting in one of his moods he didn't want any disturbance. Even routine household noise could set off an angry outburst; but never toward the kids, always toward me for not controlling them better. When he got on me, I'd get scared and get on them . . . Sometimes I'd say things like 'What's the matter with you?' 'Didn't I tell you not to do that?' 'You're going to get me hit.' And the thing was, most of the time I didn't think that they were doing anything wrong."

While at the shelter, Helen attended two parenting group meetings which, she said, "gave me a sense of who was responsible for what. The kids weren't responsible for how I was feeling and I wasn't responsible for Stan's mood. It wasn't that I didn't know these things already, but I guess with all the pressure, I needed to be reminded."

Helen practiced making "I" statements on anyone who would listen, but mostly she used them to confront Stan from the safety of a shelter telephone. "For the first time, I could talk clearly to Stan about his behavior, not just the rare incidents of violence, but the threats, put-downs and accusations which he would fire at me," Helen recalled. "I could describe what he did and tell him how I felt without either blaming him for my feelings or taking responsibility for the way he behaved toward me."

After nearly three weeks at the shelter, Helen returned home. Stan became involved with our ongoing counseling program for perpetrators of consort violence (agreed upon with Helen as a condition of her return home), and Helen began the 18-hour Parent Education Program at a community site. In talking about her first few weeks back home, Helen said:

"I felt much more relaxed and realized how much of my tension before with the kids had really been my tension with Stan. When I did get bothered with the kids, I would usually take a short time out and look at what was bothering me. At least half the time when I did this, it wasn't necessary to deal with the kids because the problem was with me.

"Stan still became angry and used name-calling and put-downs. I didn't have the same kind of fear, however, because as part of the work with Stan, he and I had agreed on a time-out process and we both seemed determined to not give in on our end of the agreement."

Helen completed the parent education course last spring and in the summer enrolled in continuing education programs in child development at the University of Delaware, in anticipation of becoming a licensed day care provider. Her application was accepted last fall and she now provides care for three children along with Michelle and Adam. "I don't know where things are going with Stan," Helen said. "There has been no violence in a year, but the put-downs and name-calling . . . sometimes they're still more than I want to deal with. But with the day care, if Stan and I don't make it, I know I've got a way to get by . . . and the best thing about it is that it really is a nice place here for the kids. I often think if I had to leave my children some place, I'd be really happy if it were a place like mine."

While the changes made by Ann and Helen may be more dramatic than those made by most program participants, both the approach used by staff members to help participants learn and apply parenting principles and the parents' receptive attitude are typical. In fact, nearly 40 percent of mothers who have been active in the Shelter Parenting Program become involved with another parenting program after they leave the shelter.

In conclusion, the Shelter Parenting Program offers a useful and often needed service at a time when its participants would seem to be overwhelmed with other important issues. However, because of the intense concern that most of the women have for their children, and the supportive manner in which the program is offered, the majority of participants welcome the services and use them productively. ■

*In addition to the Family Violence and Parent Education programs, other service components of CHILD, Inc.—a private, nonprofit organization—include two children's emergency shelters, a runaway youth program, a statewide network for runaway and homeless youth, specialized foster care for delinquent girls and child and family advocacy. Further information may be obtained from Joseph M. Dell'Olio, Executive Vice President, CHILD, Inc., 11th & Washington Sts., Wilmington, Del. 19801.

Research with Children in Shelters: Implications for Clinical Services

YOUR OPTIONS:
• MAKE A PERMANENT BREAK WITH YOUR ABUSING PARTNER, AND MAKE PLANS FOR INDEPENDENT LIVING.
• PUT OFF MAKING A PERMANENT DECISION ABOUT YOUR RELATIONSHIP AND MAKE PLANS FOR TEMPORARY LIVING ARRANGEMENTS AFTER YOU'R
• DECIDE TO RETURN TO YOU
AND MAKE PLANS FOR DOIN
AS CONSTRUCTIVELY AS PO

Photo: Allan Kaye/UNIPHOTO

by Honore M. Hughes

As public and professional awareness of the problems associated with family violence has increased, service providers have become concerned about the psychological adjustment of children who witness violence between their parents. Evidence suggesting that children who experience family violence are at risk for suffering adjustment problems and difficulties with psychological functioning derives from a number of sources. These include theories of intergenerational transmission of violence, literature on parental conflict and divorce, case studies and observations of children temporarily residing in shelters for battered women, and literature on child abuse. Results of studies in these areas indicate that hostility between parents seems to have a rather consistently detrimental impact upon the children who witness those violent interactions.

Early descriptions of the functioning of children who experience family violence reflect this negative outcome. The characteristics of children in shelters for battered women, identified through observations and interviews, included the following: restlessness and nervousness; poor academic performance; confusion because of differences between home and school environments; reticence in discussing violence; and fantasies about a different homelife. Beyond these qualities, which were observed in both boys and girls, were gender-specific traits—boys reportedly exhibited violent behavior by age three, while girls were described as withdrawn and passive. In addition, age-related patterns of behavior were identified. School phobia, enuresis, somatic complaints, nightmares and insomnia were seen among preschool and

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young school-age children, and difficulties in concentration, which affected the children's schoolwork, were also apparent.[1] Older school-age children were more likely to show gender-related patterns.

As examples of the negative outcomes described, interviews with mothers in several shelters revealed that their children's coping behaviors were of an extreme nature. Aggressiveness was reported in approximately 75 percent of the children, 55 percent were characterized as becoming very withdrawn, and 10 percent were described as having made suicidal gestures. Forty percent of the children over six were reported to suffer from headaches and stomachaches. The children were not escaping the violence in the household, since approximately 90 percent witnessed physical violence between their parents, and between one-half to three-quarters of the children were themselves victims of physical abuse.

These early reports—based upon anecdotal evidence and impressions—were later followed by investigations of the adjustment of shelter children that employed standardized, well-validated instruments to measure psychological functioning and mental health. Recently, researchers have also studied groups of children from non-violent homes to compare the psychological adjustment of these two groups of youngsters. With such improvements in research methods, more definitive conclusions regarding the mental health of children in shelters can be drawn.

However, results of current studies indicate the complexity of the situation. Different conclusions and patterns can be seen, based upon a number of interacting factors. As one might imagine, no "typical reactions" to interparental hostility could be ascertained. Rather, subgroups of children and their mothers could be tentatively identified, based upon a combination of different variables. Among these factors that seem to influence the adjustment of shelter children are the ages and gender of the children; the amount of violence they observed; their abuse status (that is, whether they were abused in addition to witnessing violence); and the mental health of the mother. Additional variables involve issues related to methodology, including the types of behavior measured, the source of the information and the methods used for assessment.[2]

Findings from different studies that used groups of comparison children indicate that shelter children seem to be in more psychological distress than comparison children, according to both their mothers and their own reports.[3] Generally, their distress is reflected in extremes of aggressive and withdrawn behavior, and many variations are seen within that basic pattern. While adjustment was measured by age in only one study, the youngest children (ages three to five) had significantly higher problem scores than school-age children. Mothers of preschoolers reported that their children had more behavior problems than the older children, with the mean score for the group above the cut-off level indicating a need for clinical treatment.

Studies are about evenly divided on whether the investigators found significant differences for boys and girls. Where differences are reported, boys receive higher problem behavior scores, and a greater proportion of boys obtain scores within the range suggesting the necessity for clinical intervention.[4] The

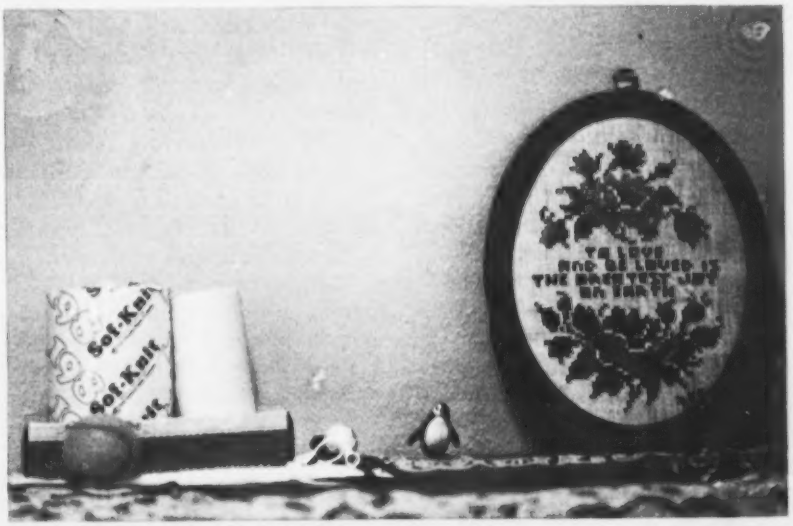

Photo: Allan Kaye/UNIPHOTO

amount of violence observed also plays a role in the results—children who have witnessed greater amounts of conflict receive higher problem scores. Gender differences are seen in the selection of problem-solving strategies, which also interact with the amount of conflict witnessed. When there is a low level of parental conflict, boys select aggressive coping strategies while girls react passively. When a high amount of conflict is witnessed, however, girls choose aggressive methods for solving problems and boys become more passive.[5]

Abuse status is an additional important variable. In the one study in which shelter children were separated according to whether or not they had been physically abused, as well as having witnessed violence, differences in adjustment were seen.[6] The abused witnesses scored significantly higher on internalizing behaviors (such as anxiety, depression and somatic complaints) than the comparison group, and scores of the children who had witnessed violence fell between those two groups. On the externalizing behaviors (disobedience, aggressiveness and destructiveness, for example), the abused witnesses' scores were significantly higher than the witness and the comparison samples, and the latter two groups were also significantly different. Again, age was an important element in adjustment: The abused preschool children received the highest scores, and a greater proportion of their scores were above the clinical cut-off level indicating a need for treatment.

The mental health of the children's mother is also an important factor to consider when evaluating the children's adjustment and planning interventions. Women coming to shelters often report feeling highly anxious; approximately one-third of them answer questions about their depressive affect at a level which places them within the range of clinical depression. The mother's history of physical abuse as a child and the ages of her children also have an impact upon her adjustment. Women who had experienced abuse as a child were much more likely to be feeling depressed and anxious than women who had not been physically abused as children. When the oldest child in a family was of preschool age or younger, the mother was also more likely to be depressed and anxious.[7]

Some differences in results are also noted based upon discrepancies in the research methodology used in the various investigations. When diverse types of behaviors have been measured, differences between shelter and non-shelter children on internalizing behaviors were noted most consistently. The higher levels of anxiety, depression and somatic concerns observed in the children by shelter workers, then, have been supported by empirical research, and the high frequency of problem behavior is likely to be substantially above the typical level of those behaviors seen in children from non-violent families.[8] In addition, many investigators obtain information regarding the youngsters' functioning only from the mothers' viewpoints; few include procedures that assess the children's feelings. In the several studies in which both mothers' and children's opinions were included, there was generally corroboration between the two points of view regarding the children's levels of distress.[9]

An additional concern regarding research methodology and its impact upon results is related to problems with self-report instruments. When school-age children are asked how they are feeling, they generally put up a facade of good adjustment and report low levels of distress and high levels of self-esteem. In interviews, however, it often becomes apparent that the youngsters have been trying to portray a socially desirable picture of themselves when, in reality, they are feeling quite distressed. This tendency seems to be especially strong for those older school-age children (nine to 12 years) who had been physically abused and for the younger (age six to eight) non-abused witness children.

To summarize, the results from the few well-designed investigations conducted to date indicate that the adjustment of children in shelters is poorer than children of similar economic circumstances who live in non-violent homes. In addition, witnessing violence seems to have a more detrimental impact upon children who are of preschool age, are boys, have observed high levels of conflict, have also been physically abused, and have mothers who report higher levels of depression and anxiety. However, these results must be considered tentative, since the numbers of families involved in this research have been small, with fewer than 10 investigations actually completed. When additional studies are conducted in which the investigators employ similar research methods, more definitive statements can be made regarding shelter children's psychological functioning and the accompanying implications for treatment.

While the conclusions drawn from research are tentative, the results currently available do lead to some recommendations for intervention. A developmentally-based approach is followed in exploring the following implications for

clinical services to children in shelters.

Recommendations for Intervention: Preschool Children

Based upon the research reviewed here, preschool children seem to be the most at risk for difficulties in psychological adjustment, due to both their age and the mental health of their mothers. To briefly summarize the findings, preschoolers in shelters show higher levels of problem behavior than both normal children their age and older children in the shelters. Indeed, in one study, nearly half of the preschool shelter children obtained behavioral ratings that suggest a need for treatment. Younger children are more likely to be physically abused, and when physical abuse is added, the situation becomes even more grim: Nearly three-quarters of abused preschool children had scores above the cut-off level indicating a need for treatment. Interpretation of these findings as indicating that preschoolers are more adversely affected by family disruption than older children is consistent with the results of studies conducted with children who have experienced parental divorce. Investigators who have studied these children conclude that preschoolers have the most difficulty adjusting to divorce and are at greater risk for psychological difficulty due to their level of cognitive development and consequent lack of understanding of their family situations.

A major impetus for directing special attention to mothers of preschool children comes from maternal ratings of their own levels of distress. The findings that more mothers of preschoolers select responses that suggest mild to severe depression and report slightly higher anxiety levels are consistent with the

results of other studies reported in the literature. Certainly preschool and younger children are more taxing to care for, placing more stress on parents just by virtue of their developmental status. Therefore, in families staying at a shelter in which the oldest child is of preschool age, the children may be at "triple risk": from the increased likelihood of having been physically abused, from problems attendant with their level of cognitive development and from the greater probability that their mothers are having difficulty coping due to depression.

Intervention with preschool children is typically conducted through their mothers, and it seems that some attention beyond the usual shelter crisis intervention, advocacy and general parenting education might be necessary. Mothers of preschoolers may need to receive supportive interventions and therapy, as well as more specific suggestions regarding ways in which they can meet their children's needs. When either the child or the mother has been subject to physical abuse, the likelihood of needing more intensive intervention grows. If the children have been physically abused, they may benefit (depending on their ages) from some individual intervention themselves. With a mother whose history includes physical abuse as a child, it is even more likely that she will need more intensive treatment than the advocacy usually provided at shelters.

Recommendations for Intervention: School-Age Children

In addition to providing advocacy and parenting suggestions for their mothers, it is also possible to intervene directly with school-age children. Service providers and shelter workers would need to be alert to youngsters' different levels of adjustment, distress and usual problem-solving styles, based upon their gender, abuse status and the amount of conflict they had witnessed. Boys who have witnessed higher amounts of conflict between their parents and who have themselves been physically abused would be the most likely to need intensive intervention, including the possibility of longer-term group and/or individual ther-

apy outside the shelter. However, the girls should not be overlooked, since there are some suggestions in the literature that detrimental effects of witnessing abuse emerge later in adolescence for girls, rather than more immediately as is seen in boys.

If a shelter worker wants to intervene to teach children new nonviolent methods and strategies for solving problems, he or she would need to keep in mind that boys and girls would probably have learned different approaches to dealing with problems, and that their strategies would also vary according to how much conflict they had witnessed. All children would need to learn appropriately assertive ways to interact—less aggressive strategies for high-conflict girls and low-conflict boys and less passive methods for low-conflict girls and high-conflict boys would need to be taught.

Service providers would need to be aware that many school-age children are reluctant to admit their psychological distress and are likely to put up a front of adequate adjustment. Whether the children admit their distress depends upon a number of factors, including their age and whether or not they have been abused. Workers might anticipate that the younger (age six to nine) abused and older (age nine to 12) witness children would be more likely to talk about their feelings of anxiety and fear and compose their children's groups accordingly. It might be helpful to divide the children by ages and developmental levels, with a mix of abused and non-abused children. Each age level group would then contain children who might be a little more willing to talk about their feelings, thus providing good models for the other children.

For all shelter children, their abuse status is also an important consideration, since children react differentially depending on whether or not they had been physically abused. As previously noted, a child's abuse status should be ascertained when planning interventions. In addition, the ramifications of abuse as a child are far-reaching, with great potential for influencing that child's adjustment as an adult. Therefore, even with a woman who does not have children or who did not bring them to a shelter, it would be important for the shelter worker to ascertain whether she was abused as a child.

Suggestions for topics to cover in children's groups also grow out of the research, although the effectiveness of group interventions with shelter children remains to be empirically evaluated. Presenting new ways for the children to cope with internalizing behaviors would be helpful—perhaps workers could teach relaxation skills to deal with anxiety and new problem-solving strategies to cope with depression. Since problems with aggression seem to be fairly pervasive among shelter children, and since aggressive/antisocial behaviors are the most likely to continue into adulthood, non-violent methods of interacting should be taught. Training in social skills and problem-solving would probably be quite helpful. Changing the children's attitudes toward violence would also make a difference, so that they would no longer accept the physical abuse they have witnessed as a routine part of life and realize that there are alternatives which include living without violence.[10] ■

[1] H.M. Hughes and S.J. Barad, "Psychological Functioning of Battered Women and Their Children: A Preliminary Investigation," paper presented at the 1983 Annual Meeting of the American Psychological Association, Anaheim, Calif. and H. M. Hughes and K. L. Hampton, "Relationships Between the Affective Functioning of Abused and Non-Abused Children and Their Mothers in Shelters for Battered Women," paper presented at the 1984 Annual Meeting of the American Psychological Association, Toronto, Canada.

[2] S.J. Barad, H.M. Hughes and K.L. Hampton, "Psychological Adjustment of Children in Shelters for Battered Women: At Risk For Domestic Violence," unpublished manuscript, University of Arkansas, 1984.

[3] A. J. Brown, D. Pelcovitz and S. Kaplan, "Child Witnesses of Family Violence: A Study of Psychological Correlates," paper presented at the 1983 Annual Meeting of the American Psychological Association, Anaheim, Calif.; H.M. Hughes, R.J. Rau, K.L. Hampton and B.D. Sablatura, "Psychological and Behavioral Correlates of Family Violence in Child Victims and Witnesses," unpublished manuscript, 1985; S.P. Kraft, J. Sullivan-Hanson, C. Christopoulos, D.A. Cohen and R.E. Emery, "Spouse Abuse: Its Impact on Children's Psychological Adjustment," paper presented at the 1984 Annual Meeting of the American Psychological Association, Toronto, Canada; A. Rosenbaum and K.D. O'Leary, "Children: The Unintended Victims of Marital Violence," *American Journal of Orthopsychiatry, 51,* 692–699, 1981 and D.A. Wolfe, P. Jaffe, S. Wilson and L. Zak, "Children of Battered Women: The Relation of Child Behavior to Family Violence and Maternal Stress," *Journal of Consulting and Clinical Psychology, 53,* 657–664, 1985.

[4] Brown et al., 1983, op. cit. and Wolfe et al., op. cit.

[5] M.S. Rosenberg, "Intergenerational Family Violence: A Critique and Implications for Witnessing Children," paper presented at the 1984 Annual Meeting of the American Psychological Association, Toronto, Canada.

[6] Hughes et al., 1985, op. cit.

[7] H.M. Hughes and S.J. Barad, "Psychological Functioning of Children In A Battered Women's Shelter: A Preliminary Investigation," *American Journal of Orthopsychiatry, 53,* 525–531, 1983 and H.M. Hughes and T.J. Rau, "Psychological Adjustment of Battered Women in Shelters," paper presented at the 1984 Annual Meeting of the American Psychological Association, Toronto, Canada.

[8] Brown et al., op. cit.; Hughes et al., 1985, op. cit.; Kraft et al., op. cit.; Rosenbaum and O'Leary, op. cit.; and Wolfe et al., op. cit.

[9] Brown et al., op. cit. and Hughes et al., 1985, op. cit.

[10] Further suggestions for serving women and children who are obtaining temporary refuge in a shelter for battered women may be found in *". . . and then we went to a safe place."* by Honore M. Hughes et al. (1981). Copies of the training manual, developed under a grant from the National Center on Child Abuse and Neglect, are available at $17.50 each from the Project for Victims of Family Violence, P.O. Box 2915, Fayetteville, Ark. 72702.

Experiential Therapy for Youths:

The Adventure Model

by Richard O. Kimball

With a trembling, tentative motion, 15-year-old Melissa takes the last step up to a perch 80 feet off the ground and near the top of a gigantic Ponderosa pine. The tree platform is one of a series of outdoor challenges constructed between trees and telephone poles with a variety of ropes, cables and bridges.

Cheered on by her group and assured by her therapist, who is holding a safety rope, the frail-looking girl with stringy hair jumps from her platform to a trapeze swing suspended in midair. Although her hands touch the swing, she has miscalculated the distance and she falls toward the ground. Almost as quickly as the jump itself, the safety rope grabs her harness and her look of controlled terror relaxes. Her group erupts into spontaneous applause and the counselor lowers Melissa into their waiting arms.

The group's reception—cheers, hugs, "high fives"—communicates without words that Melissa is a hero. Not because she caught the swing—she didn't—but because she took the existential leap from the security of the platform into the atmosphere of trust and support of those below her. The therapist gathers the group into a circle and begins to talk about what just happened.

Melissa, who is about to be discharged after six months at the Santa Fe Mountain Center, compares the fear she experienced on the platform to her anxiety about leaving the security of her therapeutic milieu. The counselor helps her to expand this metaphor and many issues are touched upon—separation, trust, support, self-confidence and risk-taking. The experience on the ropes course has helped Melissa prepare for discharge, but she has one more immediate challenge to face: Tomorrow she will embark on a 17-day wilderness expedition to the Pecos Mountains in northern New Mexico. Away from the treatment center, her bed will be a 1-inch pad and her chest of drawers a backpack.

She took the existential leap from the security of the platform into the atmosphere of trust and support of those below . . .

Located in Santa Fe, New Mexico, at the foot of the Sangre de Cristo Mountains, the Santa Fe Mountain Center is a therapeutic adventure program designed for many special populations in the state. In conjunction with state and local social service agencies, psychiatric hospitals, residential treatment centers, community mental health centers and correctional institutions, the Mountain Center has developed a variety of experiential, adventure-based projects.* By viewing our program flexibly, we have been able to adapt experiential therapy to meet the special needs of behaviorally disordered youth, substance abusers, victims of sexual assault, sex offenders, families in crisis, the anxiety disordered and others.

While we work with discrete groups based upon presenting issues, and while referrals may be accompanied by a specific diagnostic label, the psychological procedures at work are quite universal and human. Most young people come to the program burdened with some identity myth: They are "victims," "delinquents," "pedophiles" or "borderlines." At the Santa Fe Mountain Center, every youth has the opportunity to transcend these labels. When the therapist lowered Melissa to the ground in our opening scenario, he was lowering a "hero," not a "victim" of incest. Fundamental to experiential therapy is the development of self-efficacy or empowerment. We give youths the opportunity to write themselves a new life script. Our activities—rock climbing, ropes courses, extended wilderness living, whitewater rafting—are opportunities to challenge one's self-image. "Rise to the occasion!", "Go for it!" and "You can do it!" become the basis of a new vocabulary to build positive self-definition.

While the administrative offices and

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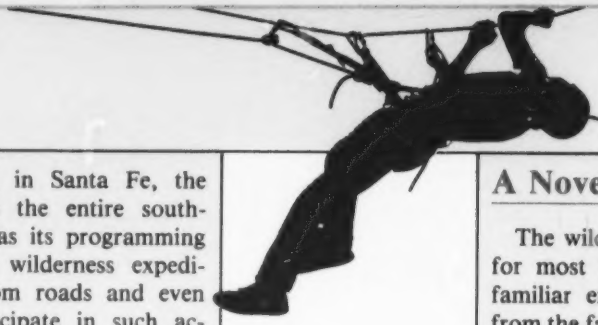


equipment are located in Santa Fe, the Mountain Center uses the entire southwestern United States as its programming domain. On extended wilderness expeditions, far removed from roads and even trails, youngsters participate in such activities as mountaineering, rock climbing, canyoneering, caving and technical river running. The program does not teach these specialized skills as ends in themselves but, rather, teaches *through* them. Within the demanding context of the wilderness, we seek to instill pride in discipline and accomplishment, commitment to action and goal attainment, trust and compassion toward others and, most important, responsibility. The central theme of all Mountain Center courses, which vary in length from three to 21 days, is that we are each, inescapably, the architects of our lives. We are ultimately responsible for the choices we make.

Underlying Concepts

The essential ingredients of experiential therapy include an emphasis on action and reflection on experience, utilization of a unique physical environment, creation of a cooperative community, programmed success and facilitation by the instructor/therapist.

The use of adventure experiences as a therapeutic tool stands in sharp contrast to traditional therapies in typical clinical settings, which are primarily introspective and analytical. "Talking therapies" presuppose a verbal ability that is often absent in adolescents. The Mountain Center assumes that *experience* is more therapeutic than *analysis*. Whereas most psychologists use counseling to change attitudes in order to modify behavior. the Mountain Center's therapeutic approach assumes that attitudinal change can best follow reflection upon new experiences and behaviors.

Experiential therapy creates situations and opportunities to *do* things, and everyday experiences form the basis for understanding, teaching and counseling. Inherent in experiential therapy is the opportunity to make mistakes. The counseling goal is to help the individual understand and learn from his or her behavior and actions.

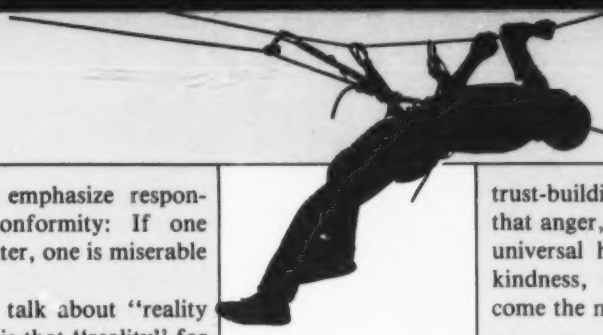
Reality for most troubled youths appears hopelessly complex.

A Novel Environment

The wilderness presents a novel situation for most people. Thrust into a new, unfamiliar environment, the youth is jolted from the false securities of a familiar setting. The outdoor environment encourages new behavioral responses in youths who may characteristically have great therapeutic resistance. Placement in an unfamiliar setting enables the individual to gain new perspectives on old patterns and assumptions. Furthermore, new activities can be enticing and fun. Thus, the young person enters a situation in which he or she is open to new problem-solving and coping techniques.

The situation is quite different from that of a conventional correctional institution or treatment center, where the usual adult roles are those of authorities and reinforcers of behavior. In such a traditional setting, the youth becomes programmed to function completely according to rules designed by someone else and seldom has an opportunity to exercise his or her own problem-solving skills or personal initiative in meaningful situations. By contrast, in the wilderness, rules are natural rather than arbitrary. The outdoor environment dictates that an individual respond flexibly and adaptively.

Photo: Joan Neary



Environmental lessons emphasize responsibility rather than conformity: If one neglects to put up a shelter, one is miserable when it rains.

Youth workers often talk about "reality therapy." The problem is that "reality" for most troubled youths appears hopelessly complex. The isolation and simplicity of the outdoors help to bring them back to basics and into a more manageable world. Human beings are context-bound; the way people act usually depends on the context they are in. The wilderness expedition shakes up and plays with what had previously constituted reality.

A Cooperative Community

The therapeutic group is at the core of the wilderness experience. Daily challenges demand a cooperative framework that requires effective group dynamics to attain personal comfort and security. Even a youth who may never have felt important to others learns that in the context of a wilderness experience her group depends upon her. A small group (eight youths and two or three leaders) offers an opportunity for the evolution of a genuine community. Cooking, map reading, shelter construction, river crossings, mountaineering, rock climbing and countless immediate problems demand cooperation and the use of each individual's strengths. A system of exchange eventually evolves: One person might be a good route finder, and another an excellent cook, while a third demonstrates interpersonal leadership under adverse circumstances. The group learns to maximize one person's strengths to minimize another's weaknesses.

The group develops cohesiveness as members struggle against daily challenges of hard hiking, climbing and the capricious nature of the weather. Occasionally, an emergency—a sprained ankle or an imminent electrical storm—may bring the group even closer. While teamwork is always essential, it is even more important during perceived exigencies.

Group cohesion results in an atmosphere that promotes honest emotional expression and sharing. Every night the group members discuss the day's successes and failures and resolve problems so that the next day will go more smoothly. Group counseling sessions become extremely candid after weeks of trust-building. Although the group learns that anger, frustration, fear and anxiety are universal human feelings, genuine acts of kindness, friendship and compassion become the norm.

Programmed Success

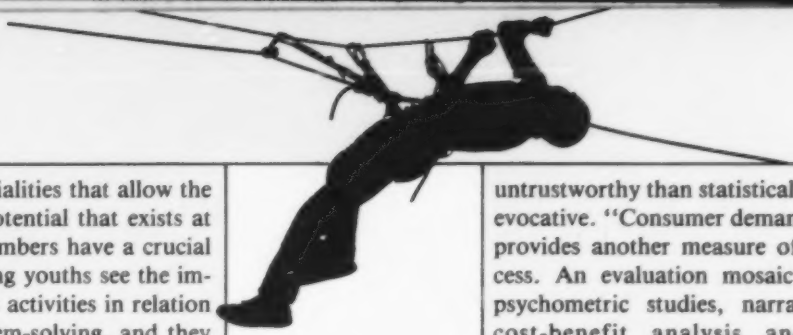
Experiential therapy is a process in which individuals face situations that challenge their sense of efficacy. Often outdoor programs emphasize the fear, stress and anxiety associated with such dramatic activities as rock climbing and neglect to emphasize the assessments, skill development and degree of support necessary to meet the challenge. Adventure programs are carefully constructed, multifaceted experiences designed to counteract patterns of failure. Challenges must be introduced incrementally so that they create tension without being overwhelming. Success triggers success. One day youths may learn how to walk efficiently, while on another day more advanced work may be taught—how to hold a safety rope for a rock climber or how to travel on snow and ice with an ice ax. A sensitive wilderness therapist carefully reads the psychological and physical readiness of each youth so that he or she is challenged but not overwhelmed. Confidence is cultivated through the successful accumulation of skills.

The Instructor/Therapist

Instructor/therapists accompany participants throughout the course. They eat the same food, carry the same weight in their packs and live under the same weather conditions. The therapists and clients are together 24 hours a day, seven days a week, for as long as three weeks. While the staff members are ultimately responsible for the safety and security of the group, they also have a lengthy curriculum of outdoor skills to impart.

Each day the group has task objectives to accomplish. The tasks, however, are secondary to the primary purpose of wilderness living, which is the creation of moments of opportunity to help individuals redefine themselves. Staff members must recognize the teachable moments of everyday life on the trail.

The tasks—rock climbing or reaching a mountain summit, for example—are consci-



entiously chosen artificialities that allow the youths to discover a potential that exists at that moment. Staff members have a crucial responsibility for helping youths see the implications of wilderness activities in relation to daily life and problem-solving, and they must help translate the symbols and metaphors that abound in outdoor challenge.

Self-confrontation does not automatically engender personal growth. Rather, growth results from reflection upon experience. Self-confrontation through adventure activities requires a highly skilled and sensitive therapist who knows when the group is ready for stress and how much it can withstand, and who can monitor and anticipate the reactions of each individual. There is only a small difference between tension that is creative and growth-oriented and tension that is defeating.

One factor in our success in a comprehensive mental health care system has been our perception of staff members first as therapists and second as outdoor instructors—our means (the wilderness) must always remain secondary to our ends (therapy). An instructor's analytical ability, writing skills and familiarity with basic psychotherapy are just as vital as his or her rock climbing or mountaineering skills.

Program Evaluation

Over the years the Mountain Center has systematically evaluated and researched its own programs. As evaluators, we have leaned toward the quantitative when we were confident that we could anticipate the decisions and questions that needed answers. We have leaned toward the narrative when our sense of what matters was tentative and evolving. Thus, strategies have ranged from classical experimental designs to narrative student accounts, sociograms and questionnaires. Outcome variables that have been investigated include dimensions of physical fitness, locus of control, global personality, self-concept and social competency, and data on recidivism and reinstitutionalization. The quantitative information is specific, reliable, disciplined and positive.

To many readers, the recitation of standard deviations, orthogonal contrasts and alph levels is dull stuff. Reports from observers, journals kept by participants and answers to questionnaires, although more untrustworthy than statistical data, are more evocative. "Consumer demand" for services provides another measure of program success. An evaluation mosaic comprised of psychometric studies, narrative accounts, cost-benefit analysis and "seals of approval" from referral agencies helps to confirm the program's efficacy.

Experiential therapy creates situations and opportunities to do things, and everyday experiences form the basis for understanding, teaching and counseling.

Summary

I have painted an idealistic picture of experiential therapy. The reality is that the problems of troubled youths usually resist quick-fix solutions. While our research efforts at the Santa Fe Mountain Center clearly demonstrate positive therapeutic change on a host of variables, program administrators would be well-advised not to oversell the long-term behavioral effects. I maintain that at the very least, by living and struggling in tandem with our clients, we are able to better understand their problems and to observe their patterns of behavior.

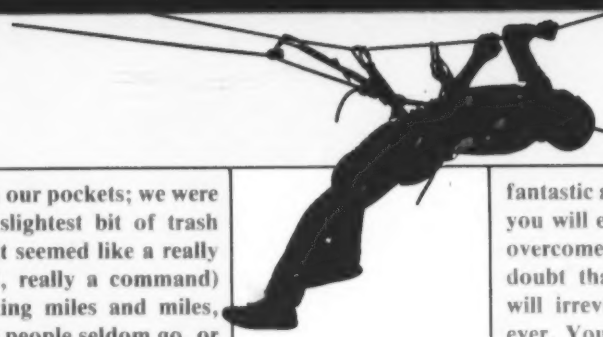
A wilderness experience allows us, the counselors, to see the ways in which these youths entangle themselves each day—with us, with other kids and with themselves. Most importantly, we dramatically demonstrate areas of power and competency to those identified as "dysfunctional" instead of merely concentrating on failure and deficiencies. For many people, this formula can be a giant first step on their therapeutic journey. ■

Journal Entries

The following excerpts are taken from the journal kept by Ron, an 18-year-old juvenile offender who has been institutionalized for many years, on a Santa Fe Mountain Center trip with his group to Canyonlands, Utah. Richard Kimball explains that the boys went through the program as "a rite of passage leaving a correctional institution and earning their parole by demonstrating positive effort on this course."

In the accompanying comments, Dr. Kimball tells us what the entries exemplify to him.

. . . let me relay a very significant thought. At the beginning of this course, we were told



to put cigarette butts in our pockets; we were told not to leave the slightest bit of trash behind. At that time, it seemed like a really arbitrary request (well, really a command) but anyway, after hiking miles and miles, and being places where people seldom go, or don't, or haven't been, I came to realize (and I don't speak solely for myself) that when walking on a high ridge lost in separate fantasies of our own, a cigarette butt or Coke can or pop-top or the least little particle implicating the past existence of another human being before ourselves tends to really blow what could have been a spectacular climax to each; in the realm of one's mind. Excuse us all for taking for granted this huge fact.

This journal entry illustrates how Ron learns to distinguish between arbitrary authority and leadership which is grounded in genuine concern—both for himself and the natural environment.

• • •

Friday, October 23, 2:30 a.m.

Well, the banquet's over, and we are at Najajo lake. This will be a little hard to express being as how my vocabulary does not hold the words to adequately do justice to this whole experience. First off, I would like to say this.

When this trip starts, and all through it right on up to the last day before the truck is loaded and headed towards home base, you will despise the weight of the pack, curse every rock, and every dirt mound, condemn every speck of dust, spit at every dirty mud puddle, and snarl at every ridge. You will want to hang, tar-and-feather and burn every ---- around you; you will cringe and smirk at every bug and spider you see, you will hate the sun and love the cold, you will hate the cold and love the sun, you will resent your very existence, and you will suffer every aching pain in your body over and over again. You will push yourself, and be pushed both mentally and physically further than you ever imagined possible, you will endure the seemingly unendurable. And as mad as it may sound, when it's all over and you've already loaded the truck and start to roll out on the roads, you will think back over those things, all of them, and you will feel this incredible surge of power over yourself, and all of those things will add up to the most fantastic and cherished adventurous memory you will ever know. You will feel the power overcome you, and you will know without doubt that you have done something that will irrevocably remain in your mind forever. You will feel the limitations of all the things you once thought impossible for you to do slip away from your mind and you will reach the ultimate realization that there are *no* limits to the things *you* are capable of accomplishing. That will be the *supreme* rush!

You will find the people you did not trust, the same people you wanted to destroy, crush and mangle are just as you are: flesh and bone, vulnerable, and human. Just people. People whose needs are the same as your own, people who live on love and affection, concern and serenity. You will find yourself strongly, overpoweringly drawn towards those people, wanting to give them something to fulfill some, one, or all of their needs. You may even be shocked absurdly by not sensing your own blindness over the days that have passed.

The biggest payoff of all is that as you feel all of these things bombarding your heart, you can rest your mind at peace because the feeling is a mutual thing. It's not happening to you alone; just like when the group watched your back and protected you as you went down that cliff, so shall the group be in harmony on thought.

So as you have your banquet, savor the flavor of joy, of peace and of people caring for one another without fear. After all, people make the world go round, but people also make people go round. This is the meaning of "The Wilderness Experience."

This expressed epiphany illustrates the dramatic rush of feelings at the successful conclusion of a vigorous challenge. Rather than the ending, however, this is the therapeutic beginning. This young man is now better equipped for the journey.

•In addition to the wilderness program for young people described in this article, the Santa Fe Mountain Center offers experiential family therapy programs, courses for adult offenders, educational trips for schools and youth organizations and seminars and training courses for professionals. One seminar, entitled *Outdoor Skill Development for Social Service Professionals,* will be held June 13–18, 1986. For further information, contact Dr. Richard O. Kimball, Santa Fe Mountain Center, Route 4, Box 34C, Santa Fe, N.M. 87501.

Stepping Out of Foster Care Into Independent Living

by Eileen Mayers Pasztor, Jean Clarren, Elizabeth M. Timberlake and Linda Bayless

Although the overall foster care population continues to decrease, the proportion of adolescents in foster care has increased to the point that adolescents now comprise nearly half of the foster care population as compared to 20 percent a decade ago. Moreover, a large number of youths are remaining in the foster care system until the legal age for emancipation.[1]

To address the needs of older youths in foster care, the Children's Bureau, ACYF, funded a project in 1983 designed to prepare older adolescents to move out of foster care into responsible living. The project, entitled "Stepping Out Of Foster Care Into A More Self-Sufficient Independent Living Network," was conducted by the Baltimore County Department of Social Services.[2] In addition to accomplishing its primary objective, the research and demonstration project realized three secondary objectives: It combined resources from the public social service, the business and the academic sectors to meet local needs and reduce a potential drain on community resources; it integrated aspects of the model into agency policy and service delivery to youth and families; and it assessed the replicability of the model by other agencies and communities. In addition to the authors, core project staff included three child welfare associates from the National Catholic School of Social Service: Deborah Brittain, Jane Park Cutler, D.S.W., and Judith Sheagren.

Project Stepping Out focused on increasing adolescents' competence in performing daily life management tasks, using resources to achieve economic self-sufficiency, improving social skills and developing psychosocial coping strengths. Based on an understanding of late adolescence as a transition period, the project sought to enhance the fit between the youths and their future social environment. Project social workers emphasized strengths and needs and provided "thinking," "feeling" and "doing" opportunities with respect to adult role functioning and social networking.

For adolescents who had experienced stressful life situations, uprooting and developmental difficulties, the project forged social support networks, which functioned as sources of support and encouraged the sharing of goods and services. Through these networks, the youths learned survival strategies, values and skills necessary for accomplishing developmental tasks.

Target Population

Project Stepping Out provided services to 31 adolescents in family foster homes and group homes. The youths ranged in age from 15 to 20, with an average of 17.1 years. There were slightly more females (54.8 percent) than males, and two-thirds of the youths were white and the remainder black. Academically, 45.2 percent were performing at a below average level, 35.5 percent at an average level and 19.4 percent, above average. Ninety percent were attending school, with 38.7 percent in the 11th or 12th grades. Three-quarters of the youths said they had previous work experience, but only a little more than a quarter had held a part-time job over four months.

Their time in foster care ranged from two months to 20 years, with an average of 6.5 years in care and 2.4 placements. Sixty-one percent were initially placed during adolescence, usually between the ages of 14 to 16 years. At the time of the project, the youths had established few bonds with their birth families. Half saw their birth mothers less than several times a month, and almost half had no contact with their fathers. Although the majority had birth siblings, only one-quarter lived in a foster care situation with a sibling.

Almost half (48.4 percent) of the youths remained in care because of behavioral, health or intellectual problems related to the child. The majority, however, remained in care because of such family-related reasons as abandonment, family inability to plan and follow through, danger of abuse or neglect, financial or housing problems and a parent who was under arrest or who had a physical or mental illness.

Service Delivery

Six service components were used to meet the project's objectives:

Project social workers. Three graduate students and three agency child welfare workers were assigned to Project Stepping Out on a part-time basis. They provided each young person with regular agency social work services as well as the project's special intervention services. Prior to the project's imple-

mentation, the service providers participated in a 28-hour training program presented by Nova University's Institute for Social Services to Families, and they received ongoing training, supervision and consultation from a field instructor provided by Catholic University's National Catholic School of Social Service.

Strengths/Needs Assessments. Adolescents' strengths and needs were explored in the areas of special interests, social and personal assets, education and employment, support systems of family and friends, values and attitudes, physical and mental health, and emancipation plan.

One assessment tool used by the adolescent and social worker was the life space diagram, which uses symbols to create a picture of the young person's experiences and feelings (on the diagram, a circle symbolizes a person, a square indicates a place and a triangle represents a situation).

For example, Jack—who had been suspended from school for fighting—drew a life space diagram that contained circles representing himself, his classmate/sparring opponent and his teacher; a triangle symbolizing the problem of suspension for fighting; and a square signifying school. In the process of drawing the diagram with his social worker, Jack was able to perceive how his anger concerning the fight that led to his suspension was related to the underlying problem of conflicts with his brother, which he viewed as the cause of his own placement in foster care. Jack realized then that his angry feelings and striking out at friends represented "baggage" from the past that he carried in the present.

By contrast, another assessment tool, the life history chart, provided an opportunity for the adolescents to probe earlier experiences with their birth families, reasons why they had entered and remained in foster care and their experiences in care.

Together, these tools enabled the youths to review the past, examine the present and plan for the future.

Task Groups. These groups, co-led by project and agency staff, included six to 12 young people who identified, discussed and practiced skills for independent living. In a session on goal identification and planning, for example, youths discussed preparation for such occupations as veterinarian, beautician and construction worker. Activities in related sessions focusing on job search, career development and maintaining employment included resume writing, practice in asking a work supervisor for assistance and discussion of how to dress appropriately for work.

A session on daily living skills stressed practice in renting an apartment, writing checks and grocery shopping, while another on social networking centered on enhancing the youths' skills in meeting and keeping friends, living with roommates, reconnecting with birth parents and siblings and maintaining ties with foster families.

One-Day Workshop. The workshop, conducted by project and agency staff, was designed to compress the knowledge and skills learned in the task groups into an extensive examination of three primary topics: housing, vocational skills and independent living skills. The youths divided into small groups that rotated among the three discussion topics, and afterwards, they prepared and shared a meal—which, participants agreed, was a highlight of the day.

Volunteers. Adults to act as role models or mentors were recruited from local civic clubs and businesses to work with adolescents who needed a one-to-one relationship with a mature, responsible adult. Volunteers completed a 4-hour training program—conducted by the Baltimore County Department of Social Service's volunteer coordinator, the National Catholic School of Social Service's volunteer trainer and a Nova University Institute for Social Services to Families trainer—to prepare them to support the adolescent's growth toward autonomy and to teach remedial skills in selected areas.

One young person in residential care was able to be discharged into family foster care because a volunteer provided transportation for the youth to out-patient treatment. Another adolescent, who found a job in a bakery, practiced making change with his volunteer while a third youth worked with her volunteer to make a new dress.

Apprenticeships. Community leaders were asked to approach potential apprenticeship providers on behalf of the project in general as well as individual youth. Profiles that included information about the young person's interests, strengths and needs regarding employment were shared with potential employers. The project was able to generate six additional apprenticeships apart from fast food services and the usual community summer employment, but only two-thirds of the youths who wanted jobs were able to obtain them. Two of the youths were placed in jobs through existing community projects.

Implementing the Project

During the 9-month period of service delivery, each of the 31 adolescents participated in an average of three of the six service components. To assess the impact of these services, researchers from the National Catholic School of Social

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Eileen Mayers Pasztor, who was co-director and trainer for Project Stepping Out under the auspices of the National Catholic School of Social Service, Catholic University of America, and Nova University's Institute for Social Services to Families, is currently a Child Welfare Associate with the Child Welfare Institute, Atlanta. Jean Clarren, the project's principal investigator, is Assistant Director for Child Welfare, Baltimore County Department of Social Services, Towson, Md. Elizabeth M. Timberlake, D.S.W., the project's principal researcher and program consultant, is Associate Professor, National Catholic School of Social Service, Washington, D.C., and Linda Bayless, Ph.D., the project's curriculum developer and trainer, is Assistant Director, Institute for Social Services to Families, Nova University, Fort Lauderdale, Fla.

Service compared the project participants with a control group of 29 adolescents who were also in the foster care program of the Baltimore County Department of Social Services but were not receiving project services. To control for the influence of possible differences between the two groups, a pre- and post-test design was used. The experimental group's growth was measured by a psychosocial functioning scale and an emancipation social functioning scale.[3]

On the emancipation social functioning scale, the difference between the experimental and control groups was substantial. Adolescents receiving project services achieved significantly more growth in the social functioning skills needed for emancipation, as measured by their total score in the areas of independent living, employment and social network skills, than did those adolescents who received no project services.

On the other hand, the percent of difference between the two groups on the psychosocial functioning scale was not significant. Adolescents participating in project services did not grow significantly in psychosocial functioning as measured by eight indicators: self-image, peer relationships, adult relationships, self-control, motivation, handling the learning demands of school and home, learning style and expression of feelings.

Impact on Adolescents

That the experimental group achieved substantially more positive changes than the control group in social functioning was not surprising for a variety of reasons. Five of the services focused primarily on the knowledge, values and skills basic to social functioning after emancipation. Since the social functioning tasks and skills necessary for sorting out early career interests, functioning well on the job and handling day-to-day experiences are concrete, they are probably learned and incorporated early.

Experiences dealing with employment skills and issues are also likely to capture the young person's interest, since jobs and spending money are considered both current and future needs. Nor should satisfaction derived from the immediate monetary rewards of the job be overlooked. While their actual skill development in the areas of employment, independent living and social networking may have been slight, these youths perceived themselves as having grown in their ability to step out of foster care into independent living.

The lack of significant, positive changes in the general level of psychosocial functioning was disappointing but not surprising, since only the social work service component addressed psychosocial issues as well as issues related to social functioning and coping with independent living. The foremost reason for this lack, however, was that the project was designed to meet the short-term goal of preparing adolescents for independent living rather than addressing their residual developmental conflicts and problems. Given the youths' vulnerability, the psychosocial developmental tasks inherent in the transition from foster care to independent living take on special significance for them and require more than short-term social work remediation and personal growth.

Impact on the Agency

The six service components have been integrated into agency policy, programs and practices to varying degrees. The need for a core unit of social workers with specialized training to provide individualized services and mobilize supplementary resources for older youths in foster care has been clearly identified, and Baltimore County has an established Specialized Adolescent Program Unit which provides most of the Stepping Out service components. For agency staff with clients not served by the Specialized Unit, the project offered some exposure to the knowledge, values and skills basic to competence-oriented emancipation services. Thus, all adolescent clients could be encouraged to complete life space diagrams, strengths/needs assessments and a mutual action plan.

Although the adolescents responded well to the task groups, this component is difficult to incorporate into standard agency service delivery because of scheduling and transportation problems. While it is also difficult to coordinate transportation for youths who participated in the one-day workshop in independent living skills, agency staff members felt that evaluations from the workshop were positive enough to replicate this service periodically.

Although there were fewer volunteers than desired, agency staff believed the volunteers were positive role models for the youths and, as a result, the agency volunteer coordinator is establishing a volunteer mentorship program for adolescents in foster care. As with the volunteers, there was a scarcity of apprenticeships. Because time constraints hampered the project's community liaison efforts to set up apprenticeship opportunities, most jobs came from an established county program for youths with special needs.

Replication

Although the project's combination of resources was quite effective in meeting the needs of the target population, there were organizational, scheduling and transportation problems that developed when service providers were brought in from the outside. Overcoming these obstacles required great expenditure of time and effort that is cause for concern in setting up future service delivery programs. While the project's emancipation services achieved positive results, the age-old child welfare dilemma of time, cost and staff remains to inhibit replication.

Recommendations

Both the positive outcomes and barriers encountered in service delivery have implications for future foster care policies, programs and practices. These implications are the basis for the following recommendations:

- To help move youths in foster care into independent living, agencies need to provide the six service components of Project Stepping Out. Agency social workers, for example, need specialized caseloads and training to provide individualized services and mobilize resources for older youths in foster care. Instead of focusing on problem-oriented assessment and intervention, the emphasis should be on each adolescent's strengths and needs. To make task groups and workshops accessible as well as available, agencies need to develop support systems to solve scheduling and transportation problems. Agency staff should also invest time and energy in community development, education and liaison activities to mobilize apprenticeship and volunteer resources.
- Agencies need to create training programs for foster parents that would provide information about the developmental needs of older adolescents in foster care and the goals of independent living. Such programs have to teach skills that would prepare foster parents to support adolescents' growth toward self-sufficiency, as well as skills for working with volunteers and other community resources available to youths in foster care.
- Since service providers have been sensitized to issues of separation and loss, and identity development and emancipation, by their own experiences, approaches should be developed to facilitate service providers' self-awareness and help them keep their own issues distinct from those of the youths with whom they work.
- Agencies need to begin to work with youths toward the goal of emancipation at a much earlier point in their foster care experience. Adolescents in foster care need help to resolve residual developmental conflicts and problems as well as current problems in making the transition into independent living.
- For clarity in planning, service delivery has to be divided into three phases: intake, continuing service and termination. Many service structures and technologies are common to all three phases and yet have different emphases or uses in each phase.
- Support and rehabilitative services for birth families are crucial to achieve permanency planning goals and to develop their ability to serve as support networks when their adolescents move out of foster care into independent living.
- Finally, agencies have to approach the goal of emancipation not simply as movement from one place to another but as a multidimensional process designed to enhance the young person's growth toward autonomy and mastery of life experiences. Transitional funding must be provided for older youths in foster care to meet basic needs and enable them to build resources toward the goal of full emancipation.

Conclusion

Without an explicit policy commitment to individualized service planning for older youths in foster care, agency programs and social work practice will not meet their critical needs. Without clearly defined federal, state and local foster care policies and allocation of funds, it is difficult for agencies to establish or sustain programs and resources. It is only with such programs as Project Stepping Out that social work staff can create and use appropriate intervention techniques to help older adolescents move out of foster care into responsible living. ■

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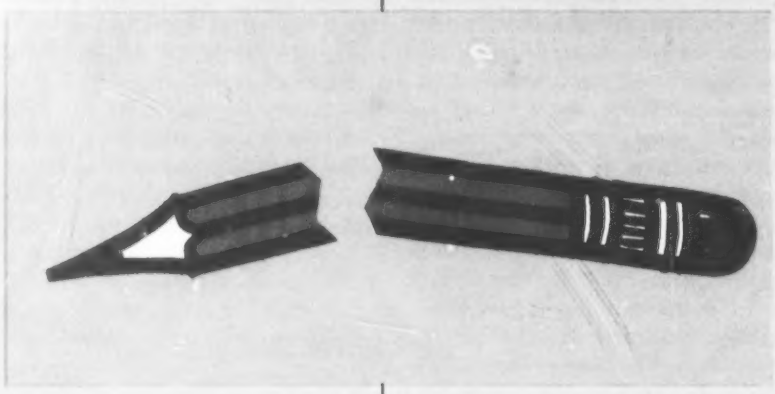
[1]See R. Hubbell, *Foster Care and Families*, Philadelphia, Temple Press, 1981; E. Timberlake, J. Cutler and J. Strobino, *A Study of the Children in Foster Care in One County Department of Social Services*, Washington, D.C., National Catholic School of Social Service, 1980; A. Gruber, *Children in Foster Care*, New York, Human Sciences Press, 1978; A. Shyne and A. Schroeder, *A National Study of Social Services to Children and Their Families*, Washington, D.C., National Center for Child Advocacy, Westat, 1978.

[2]Baltimore County Department of Social Services, National Catholic School of Social Service, Institute for Social Services to Families, *Final Report: Project Stepping Out of Foster Care Into A More Self-Sufficient Independent Living Network*, DHHS, OHDS, ACYF, Children's Bureau, Grant 90-CO-0223/01, 1985.

[3]These measures are described in the project's *Final Report*.

Book Reviews



Silent Screams and Hidden Cries: An Interpretation of Artwork by Children from Violent Homes

Agnes Wohl and Bobbie Kaufman, under the auspices of the Coalition for Abused Women, Inc. (New York, Brunner/Mazel, 173 pp., $20.00)

Reviewed by Christine deLange

At a time when family violence has increasingly drawn the attention of both the helping professions and the community at large, *Silent Screams and Hidden Cries* underscores the tragedy of the effects of violence on children. In presenting their findings from a 2-year study of the drawings of children of battered women, the authors reveal the profound effects of family violence on the children as they analyze, with great sensitivity, the artwork of 18 elementary school-aged children who not only witnessed the domestic violence in their families but were themselves victims.

In Chapter 1 the reader is introduced to the authors' perception and methodology in clear layman terms. The application of art therapy and its usefulness in providing insight into children's emotional disturbances are described in each of the subsequent chapters. Wohl and Kaufman outline the role of the mental health professional in defining the use of therapeutic activities, which assist children in expressing feelings they fear revealing even to themselves. The 50 drawings of houses, trees, families and human figures, reproduced in Chapters 2 through 5, are accompanied by detailed vignettes that convey the impact of family violence on each child. The interpretive discussions at the beginning of each chapter provide a compassionate view of the traumatization each child has experienced. The drawings and their analysis bring the reader to conclude the seriousness of the children's experiences, while the data (background information on the families) presented brings the reader to conclude the reality and severity of the family situation.

In the final chapter, the authors summarize what they learned and make recommendations. The problem set forth in this book challenges the community to respond by developing systems of early detection of domestic violence, the hypothesis being that violence begets violence and only through early identification and intervention can we eradicate the cyclical effects of violence. The study described here tested that hypothesis and, in fact, substantiated the aggressor and victim tendencies in children from violent homes. Now the challenge is brought to the community at large and its helping professions to define the tasks that lie ahead. Will we continue to be a violent community? *Silent Screams and Hidden Cries* may help the reader examine the consequences of that decision.

Christine deLange is a Washington, D.C. area-based consultant on child abuse and family violence and a Board Member of Virginians Against Domestic Violence.

Parents, Children, and Change

Edited by L. Eugene Arnold (Lexington, Mass., D.C. Heath and Co., 204 pp., $21.00)

Reviewed by Gail Gordon

Parents, Children, and Change is a collection of 13 essays written by professionals from a variety of disciplines including psychiatry, psychology, education, economics, medicine, sociology, theology, nursing, social work and law. It is an attempt to show how change in

the technological fields has affected the lives of people, especially the parent-child relationship in such basic areas as nutrition and feeding patterns, sexuality, employment and family lifestyles. Each author has chosen his or her particular field of interest and related it to those evolutionary changes that are happening around us and that are affecting how our children are being reared. A bibliography at the end of each chapter allows the reader to pursue the individual subjects further.

The book is divided into four sections: Our Changing Society and Changing Families; Nurturing the Parent/Child Relationship; Food in the Future Family; and When the Parent/Child Relationship Goes Public. Some of the authors—like Jessie Bernard, a sociologist; Urie Bronfenbrenner, a psychologist; L. Eugene Arnold, a psychiatrist,

pediatrician and parent educator; and Mary Calderone, a physician and authority on sexuality—are well-known from their many publications. Others have been primarily involved in developing programs in the Ohio area. All the essays, however, are clear, well-written and informative. They share a variety of conclusions that are summarized at the end of the book.

The basic thesis is the fact that change is inevitable throughout the world and will affect us as a species. If we are to deal with these changes in a constructive manner, communication within families and among professionals is critical. So far, change has produced the following phenomena:

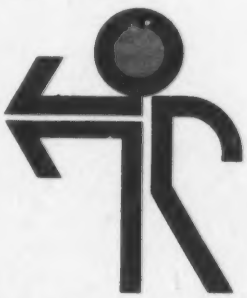
- We have more single parents, mostly women, who have been forced to enter the job market.
- Poverty, unemployment and violence in the family have increased.
- More people depend upon the public sector for the satisfaction of their basic needs than ever before.
- There is an infusion of technology in both the workplace and in how our food is produced.

Coming from the fields of child development and parent education, I found Urie Bronfenbrenner's essay particularly stimulating. He raises five questions that are basic to human survival. What are the needs of children? Which of these needs have to be met by parents? What are the needs of parents? How well are these needs of children and of parents being met in our changing society? What is to be done? According to him, "Our task is to reweave the unraveled social fabric. We have to rebuild the connections between home, the school, the workplace, the community, and the neighborhood. We have to recognize the fact that families are not self-sufficient."

It is also Arnold's conclusion that parents need help in order to deal with change, and that the various disciplines must work closely together in order to mobilize the challenge created in the community to deal with it. This book is particularly good in synthesizing the issues that concern many of us in the human services and that are often dealt with in the media. I would highly recommend it to anyone concerned about where our society is headed, since it is both stimulating as well as informative.

Gail Gordon is Coordinator of the Grandmother Program, Little Sisters of the Assumption Family Health Service, New York City.

books in brief



National Directory of Children and Youth Services '86-87

American Humane Association and Bookmakers Guild, Inc., 1430 Florida Ave., Suite 202, Longmont, CO 80501, 571 pp., $49.00 (plus $4.00 shipping and handling)

This fourth edition of the National Directory lists some 2,500 licensed private providers of residential care, treatment and assistance services, as well as social service, youth, juvenile justice and health agencies at city, county and state levels. The comprehensive reference handbook also contains guides to runaway youth centers, national and international organizations serving children and youth, managers of federal programs and Congressional committees responsible for social services, health and juvenile justice legislation. A 15-page buyers' guide to products and services is also included.

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Kids and Drugs

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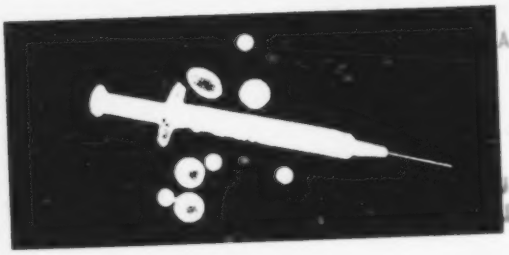

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Training the Parents of the Future

Working Together in Kansas

The North Carolina Experience

HE23.12:

May-June 1986
Volume 15 Number 3

children today

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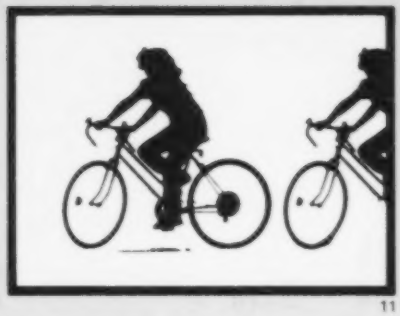

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2 FYI: Home Alone . . . Child Care Facts . . . Child Protection and Decision Making

5 Kids and Drugs: Why, When and What Can We Do About It? by Coryl LaRue Jones and Catherine S. Bell-Bolek. While peer influences may prove hazardous in adolescence, the family may well prove to be the most enduring point of prevention or intervention.

11 Bicycles, Roller Skates and Skateboards: Safety Promotion and Accident Prevention by Phillip M. Wishon and Marcia L. Oreskovich. Young people need to be aware of potential hazards in recreational activities, and they need to establish attitudes of safety.

16 A Model for Child Mental Health Services: The North Carolina Experience by Lenore Behar. As this intensive statewide effort indicates, it is possible to serve seriously disturbed, violent and assaultive adolescents in community based settings.

22 Parents and Mental Health Program Leaders: Working Together in Kansas by John VanDenBerg and Richard Donner. The influence parents can have on developing services for children and adolescents with severe emotional problems can be greatly enhanced by agencies seeking them out, listening to them and learning from them.

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26 Pregnancy and Birth-Related Brain Disorders by Leslie Fink. Although it once seemed simple to say that a specific event, such as birth trauma, caused brain disorders, a recent study shows that it is nearly impossible to pinpoint a single cause and its effect.

28 Training the Parents of the Future by John Madeley. An international program teaches older children to care for their younger brothers and sisters.

32 Channel One: An Intergenerational Program At Work by Margery Allen. A food co-op operated by senior citizens and high school students involves the entire Rochester, Minnesota, community in growing produce, collecting food and fundraising.

35 Book Reviews: Growing Up Poor
Controlling Stress in Children
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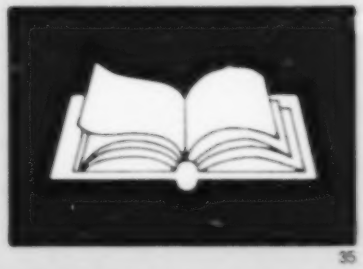

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FYI / Worth Noting

Save the Children Day... On May 1, the 9th annual Save the Children Day, youngsters again came to Washington, D.C. to testify before the United States Senate about problems they face and insights they share as children. But this year the kids also got to ask questions. After the first panel of children presented their testimony in the traditional manner and responded to questions from Senators, the second panel of children reversed the roles, asking members of the Senate Children's Caucus Policy Forum on Save the Children Day about such issues as poverty, teenage parenthood and drug and alcohol abuse. "The young people had us in the hot seats and I think the learning experience was invaluable for all," said Senator Christopher J. Dodd (D-Conn.), chairman of the Children's Caucus.

Working Mothers...In a 3-stage research project, the National Council of Jewish Women's (NCJW) Center for the Child is studying the rapidly changing needs of families in which mothers work. Currently, NCJW volunteers across the country are surveying employers in their communities to determine policies and benefits--such as medical care, maternity leave and infant care leave for mothers and fathers--that the workplace provides to support family formation. Several thousand businesses, ranging from large corporations to corner grocery stores, will be included in the survey. In the second stage of the project, NCJW volunteers will interview at least 2,500 working women during their last trimester of pregnancy to investigate the relationships between parenting decisions and the availability of "family benefits" at work. Finally, follow-up telephone interviews will be held with these women four months after childbirth to see what decisions were actually made regarding work and parenting, and why. Preliminary data from the "Mothers in the Workplace" survey is expected to be available later this summer, and final data will be given to policy makers at state and federal levels.

FYI

Home Alone

The ideas and experiences of parents, communities and adult care providers seeking to improve the lot of children in self-care, together with a description of programs, strategies and policies that can be adopted toward this goal, are explored in *When School's Out and Nobody's Home*, a booklet published by the National Committee for Prevention of Child Abuse (NCPCA).

The 53-page publication is based on information generated by the first national conference on latchkey children convened in 1984 by the NCPCA; the School-Age Child Care Project of Wellesley College Center for Research on Women; and Wheelock College. Funded under grants from the Meredith Corporation and the William Wrigley Jr. Company, the booklet was prepared by Peter Coolsen, former NCPCA associate director; Michelle Seligson, director of the School-Age Child Care Project; and James Garbarino, president of the Erikson Institute for Advanced Studies in Child Development in Chicago.

The issues of self-care, the authors argue, are not only those of safety concerns and neglect, but also those related to quality of life and enrichment. Examples of successful measures spearheaded by local communities and states encourage the notion that the problem is solvable.

The first two chapters discuss the impact on school-age children (ages six to 15) of having parents in the workforce and summarize what research reveals about children in self-care regarding academic and social competence, behavior, and psychological and emotional development. The following chapters focus on supervised alternatives to self-care, and ways of finding school-age child care programs in public and private schools, Ys and other youth-serving agencies, day care centers, municipal recreation centers and religious institutions.

The chapter entitled "Self Care Plus" evaluates a variety of supportive services that parents can use when the age and maturity of the child, the safety of the home and neighborhood, and the quality of parent-child communication permit an acceptable self-care or sibling care arrangement. Among the supportive services described are educational programs to promote children's health, safety, and life skills and foster self-sufficiency and self-esteem; community telephone reassurance hot lines that provide guidance, emotional support and assistance in emergencies; and family day care check-in programs and block parent programs, which offer some degree of adult supervision without the resource demands of the larger, school-based or other community institution-based programs. Other supportive services involve child care for sick children, including company or government sponsored programs that use trained health care aides in the home or combine in-home and center care.

The final chapter describes what citizens and community leaders can do at local, state and national levels. The authors observe that awareness about the need for services for latchkey children has had its strongest support at city and county levels and that community activity often stimulates interest at higher levels of government. A number of states have successfully initiated legislative and budgetary action. Such employer-supported efforts as information and referral services that help parents find school-age child care, employee voucher programs, and collaboration with community task forces to explore the development of improved child care services have been advocated or implemented.

Copies of *When School's Out and Nobody's Home*—which includes an appendix of selected resources for those interested in developing local programs—may be obtained for $4.00 each from the National Committee for Prevention of Child Abuse, 332 S. Michigan Ave., Suite 950, Chicago, Ill. 60604.

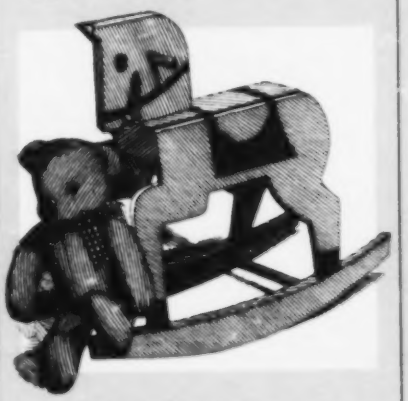
Child Protection and Decision Making

How child protective service workers make decisions and how they can be assisted in making critical practice judgements is the focus of *How We Make Decisions in Child Protective Services Intake and Investigation*, a 68-page book resulting from a 17-month project conducted by the National Legal Resource Center for Child Advocacy and Protection of the American Bar Association. Funded under a grant from the National Center on Child Abuse and Neglect, the 68-page resource outlines factors that influence child welfare workers' decisions regarding risk to a child and subsequent plans for intervention. The booklet—which focuses primarily on assessing risk—is recommended as an aid in training and supervision, as well as a self-instructional guide for decision making.

Material is presented in three sections: understanding how decisions are made; assessing decision-making practices; and suggested guidelines for decision making in case situations. Among the topics highlighted are factors that govern information processing, common errors in decision making, case and risk assessment, state laws and agency policies, critical information on family characteristics and levels of intervention.

A brief overview of research findings on factors that influence worker decision making in child welfare—including substantiation of abuse, service delivery, court involvement and placement—is featured for both researchers and practitioners. The book also contains a listing of references and an appendix on indicators of risk. Information not covered includes development of skills in interviewing, dealing with client hostility and conducting an investigation.

Copies of the publication, at $4.50 each, are available from the American Bar Association, National Legal Resource Center for Child Advocacy and Protection, Order Fulfillment, #549, 750 North Lake Shore Dr., Chicago, Ill. 60611.



Creative Play for Young Children

Suggestions, ideas, and enjoyable, easy-to-do activities to help parents and other caretakers forge a closer bond with their infants and toddlers and motivate young children to learn through play are highlighted in *Look at Me: Activities for Babies and Toddlers*, a handbook prepared by Carolyn Buhai Haas Publishing, Inc. The 221-page, illustrated resource offers caretakers guidance in communicating and sharing with babies and young children from birth to age three, and features games and other creative projects for young children that require only a few basic materials other than "saved" household items.

Divided into sections and organized, wherever possible, according to developmental levels, *Look At Me!* can be adapted to various age levels, needs and occasions. Included are directions for making crib and room accessories, toys, first-books, nursery rhymes, finger-plays, poems, songs and movement games, picture puzzles, arts and crafts, nature and science projects, party invitations and refreshments, and easy, nutritious recipes.

Look At Me! is based on a film series of the same name prepared by Parents As Resources (PAR), a training program for parents and teachers of young children that includes books, materials and a syndicated comic strip.

In addition to *Look At Me!* ($8.95), CBH Publishing has produced a wide range of materials designed for parents, grandparents, teachers and other caretakers to use with young children. Further information may be obtained from CBH Publishing, Inc., Box 236, Glencoe, Illinois 60022.

Child Care Facts

A 4-page fact sheet on child care in the United States has been compiled by the National Commission on Working Women, an organization that focuses on the needs and concerns of the approximately 80 percent of

women in the work force who are concentrated in low-paying, low-status jobs in service industries, clerical occupations, retail stores and factories.

Included are data on working mothers, the types of child care they use, the approximate costs and the kind of assistance available to providers and parents.

The Child Care Fact Sheet—which may be reproduced and distributed by interested organizations—is available free from the National Commission on Working Women, 1325 G St., N.W., Lower Level, Washington, D.C. 20005.

Companions For Latchkey Kids

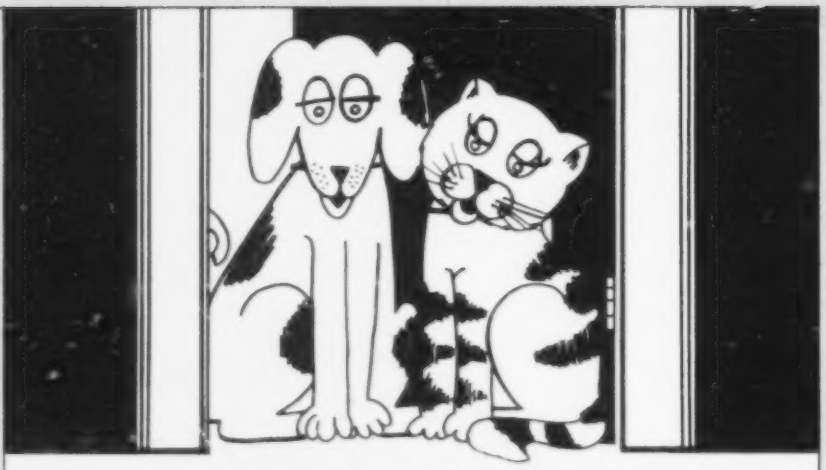
What can be done to help alleviate the stress, boredom, fear and loneliness experienced by many of the 10 million children under age 14 who take care of themselves after school while their parents work? According to Dr. Lynette Long, child psychologist and co-author of a handbook for latchkey children, the answer may be a 4-footed friend.

Long believes that often the addition of a dog or cat to a child's life "can make all the difference in his or her attitude toward being alone at home. The difference is as profound as a youngster being greeted at the door by an enthusiastic and adoring dog or cat, versus opening the door to an empty and echoing house. For latchkey children, the dog or cat is more than a pet: it becomes a guardian, protector, companion and best friend."

In consultation with Long, the Pets Are Wonderful (PAW) Council—a national, nonprofit, public service organization that seeks to communicate the rewards of responsible dog and cat ownership—has developed a trio of free materials designed to help working parents help their children. Founded in 1981, PAW serves as an information clearinghouse on dogs and cats and the "human/companion animal bond"—the science of people/pet relationships.

A parent's guide, *Pets Are Wonderful Companions for Latchkey Children and Others on Their Own*, offers suggestions on choosing a dog or cat and provides insights on the various ways a pet can ease a child's loneliness by acting as a playmate, confidant, companion and protector. The booklet also features tips to help ensure a child's safety until an adult arrives home.

Also available is a poster featuring PAW mascots "Buddy" and "Betsy" for children to color in, with blank spaces for important phone numbers and a list of safety tips. When colored, the "artist's" work can be displayed on the refrigerator or near a phone, so that emergency phone numbers are easily accessible.



BUDDY AND BETSY

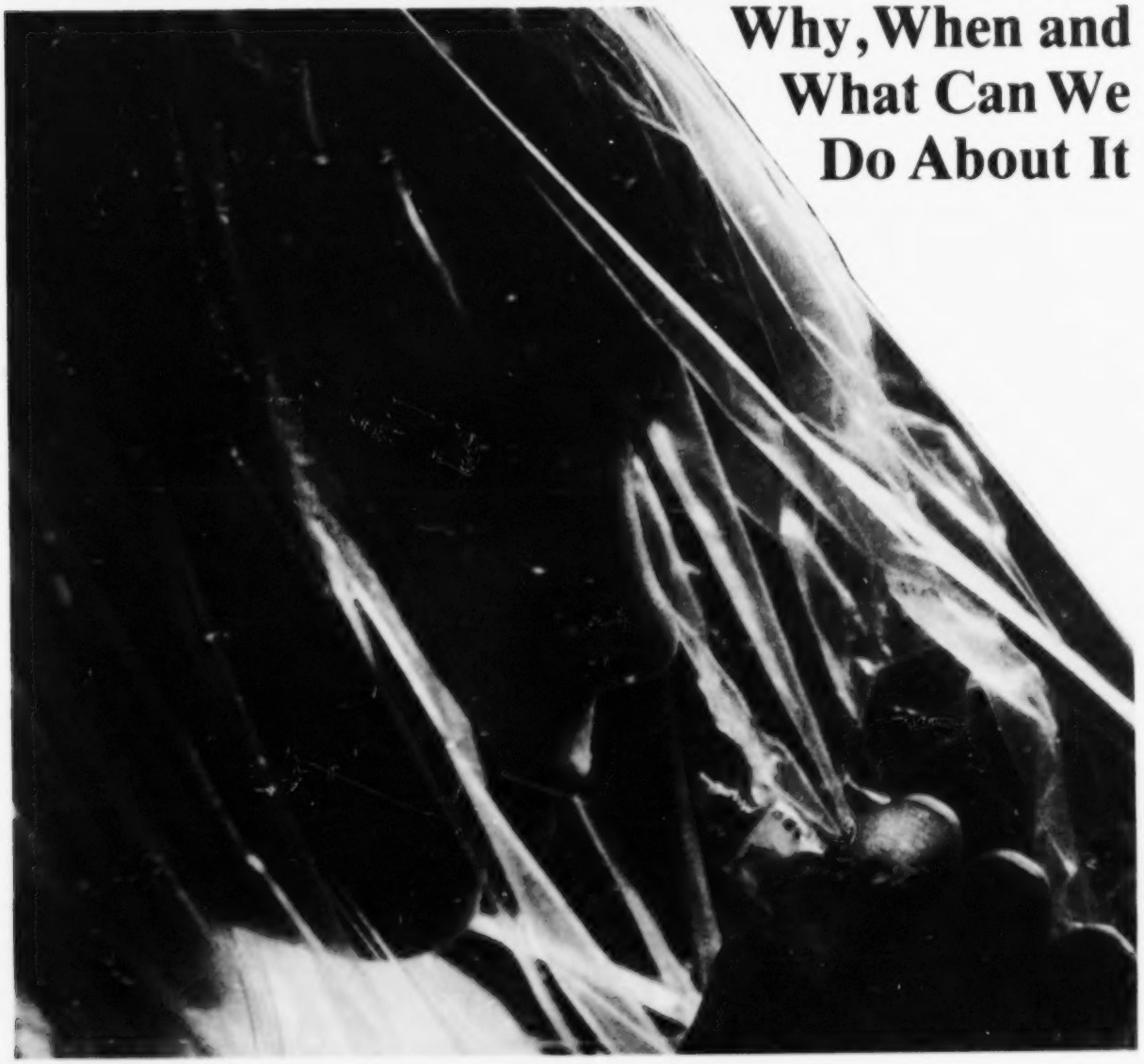
Buddy and Betsy team up again in a coloring book, *Having Fun on Your Own With Buddy and Betsy*, which contains drawings that children can color as they read safety tips, and recommends safe, indoor playtime activities.

In addition to these free publications, PAW sponsors special consumer education programs and activities to enhance public awareness about responsible pet ownership and how pets contribute to human health and happiness. Among these efforts are school programs, professional community relations and guidelines materials for animal shelters, a National Shelter Awards program, public service broadcast materials, a national spokesperson network of leading pet experts and researchers, and a traveling mall exhibit.

Further information on PAW programs and publications is available by contacting Pets Are Wonderful Council, 500 North Michigan Ave., Suite 200, Chicago, Ill. 60611.

Kids and Drugs:

Why, When and What Can We Do About It



A 5-year decline in drug use among American high school seniors stalled in 1985. That year, according to figures from an annual national survey conducted by the Institute for Social Research, University of Michigan, 61 percent of the students surveyed reported trying an illicit drug at some time—and 40 percent used a drug other than marijuana.[1]

Although the 1985 levels are half

. . . prevention efforts need to explore what drug use means to teenagers. . . and to respond to the values of adolescents. . .

by Coryl LaRue Jones and Catherine S. Bell-Bolek

of what they were in their peak years in the 1970s, they are higher than 1984. Only the use of LSD, methaqualone and the amphetamines (second to marijuana as the largest class of illicitly used substances) continued to decline, while the levels of use of cocaine, PCP and opiates other than heroin, which had been declining, increased in 1985. Cocaine had been tried by 17 percent of the students in 1985 as compared to 10 percent in 1976. It is interesting to note that while nearly 80 percent of seniors acknowledged the harmful effects of using cocaine, only 34 percent saw much risk in experimenting with it. More than 70 percent saw harm in using marijuana (up from 43 percent in 1983), and almost 60 percent listed potential harm as their reason for quitting.

Although nationally only five percent of seniors had tried PCP, its use increased in epidemic proportions in certain cities (for example, Washington, D.C., Los Angeles and Detroit). Because of the sense of omnipotent power associated with PCP use and its low manufacturing cost, this regionalized pattern of use may spread among disadvantaged urban youth.

Despite age factors affecting legality of use, alcohol and cigarettes are defined as licit drugs. Five percent of high school seniors reported daily use of alcohol, and 39 percent reported participating in heavy party drinking (five or more drinks in a row). One in five seniors is a daily smoker. While this rate is lower than the peak year of 1977, it indicates an increase from 1984. Other tragedies are that experimentation with tobacco is occurring at increasingly younger ages and that young people are increasing their use of smokeless tobacco.

The question of how to prevent drug abuse can best be answered if we can understand something about why an individual begins to experiment with drugs and when such activities are likely to take place.

Gateway Theory and Gateway Drugs

According to the gateway theory developed by Denise Kandel, a predictable sequence of use of specific drugs exists: legal substances (first tobacco, then beer and wine and progressing to hard liquor), then the illegal drugs (marijuana, then other illicit drugs). Both Kandel and Richard Jessor report that adolescents rarely proceed directly from the "gateway drugs" (tobacco, beer and wine) to illicit drugs such as heroin and cocaine without the intermediate steps of using hard liquor and marijuana.

Of course, this sequence of drug use is not absolute. In some communities, inhalants are the first drugs used by children, particularly children in ethnic minority groups. In addition, some adolescents will try a drug, then stop using it.

Lee Robins noted that persons who initiated drug use very early (under age 15) or late (after age 24) were those who tended to develop the most dysfunctional drug use patterns. Underlying psychiatric problems were associated with early and late onset of drug use. From her research with young children in Washington, D.C., Patricia Bush would add a preliminary stage: salience of use of substances in the home—meaning involvement of the child in lighting cigarettes, serving drinks and taking medicines without supervision.

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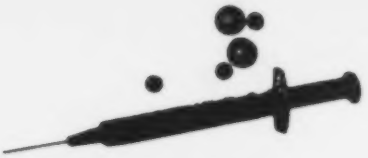


. . . drug abuse is a function of the adolescent's social interaction and experimentation with lifestyle.

The findings discussed here and in the following section are reported in a recent monograph, *The Etiology of Drug Abuse: Implications for Prevention,* published by the National Institute on Drug Abuse.[2]

Why and When

The peak years for initiating and using drugs are between the ages of 14 and 21. The fact that experimentation with and limited use of tobacco, alcohol and marijuana take place predominantly in social situations, with solitary use relatively rare, suggests that in the majority of cases, drug abuse is a function of the adolescent's social interaction and experimentation with lifestyle.

The mobility of adolescents brings exposure to new associates, and the egocentricity of young people makes them feel invulnerable—until they try to stop use. With rare exception, the psychopharmacological factors associated with compulsive drug use are hidden for a while and develop after increased, prolonged and regular patterns of drug use. After a regular pattern of use is established, in the case of drugs with an addictive potential, the physiological reinforcing properties and fear of withdrawal appear to contribute to the adolescent's maintaining a regular pattern of use independent of social context. The social context then becomes servant to the acquisition of drugs.

The "I can stop whenever I want to" syndrome appears to dominate adolescent thinking, regardless of warnings from parents and teachers. From a developmental point of view, adolescents wish to make decisions for themselves. In the early stages of experimental use, they also perceive certain social and feeling states as benefits. Even the most moralistic and rigid of preadolescents (actually, most preadolescents fit this pattern) can be vulnerable when they begin to personalize their own value systems through testing the values of others.

Within this framework, factors that increase the likelihood of initiating drug experimentation include coming from a home in which parents, older siblings or other family members smoke, drink or use drugs; living with a family that tolerates drug use or believes it is harmless or an expected aspect of adolescent behavior; and having friends who use drugs or approve of their use. Other factors include the child's need to explore developing feelings and to search for something to make him or her feel good about life.

The glamorous portrayal of drug and alcohol use in the media also contributes to experimentation. Even the identification of drug taking as a severe risk provides a fascination for the risk-taking adolescent. For some adolescents, risk is not a deterrent but a challenge.

Biological vulnerability to dysfunctional drug use is a major possibility, as research evidence is indicating with regard to alcoholism.

Disciplinary tactics used by adults can also be a factor in influencing a young person's drug use. Diana Baumrind reports that children of parents who use authoritative, in contrast to authoritarian or permissive, discipline techniques are more inclined to be rational abstainers from drug use.

Differences in the values and aspirations of young people also influence their risk of drug abuse. A desire for independence based on achievement is one of the strongest protective factors against drug abuse and to cessation of drug use after experimentation. Youths who are aware and knowledgeable about the health, social and legal consequences of drug abuse and who care about their health and future tend to be less likely to experiment with drugs unless they have psychological problems.

Substance users differ from nonusers in their social behaviors. Nonusers report more involvement

Disciplinary tactics used by adults can also be a factor in influencing a young person's drug use.

with extracurricular activities, such as sports, clubs and part-time jobs, while drug users tend to be more involved in sexual activity, truancy, delinquency and hyperaggressive and rebellious behaviors and to have poor relationships with others. Which problem behavior precedes another is an open question.

Jessor believes in the existence of a syndrome of health-compromising behaviors, which he calls problem behavior, and which include drug abuse, early sexual activity, truancy and delinquency. This problem behavior theory leads intervention experts to suggest that prevention efforts should focus on the underlying determinants of these problem behaviors rather than on drug abuse as an isolated behavior.

Baumrind takes a different stance. She believes that risk taking is a normal developmental attribute of adolescence, a part of the process that begins when the child risks taking his or her first step, and that labeling a child delinquent for such behavior may result in a self-fulfilling prophecy. She warns that since adolescence is a time of individuation, coercive approaches that frustrate attempts to gain independence may stimulate rebellion and increase, rather than decrease, drug use.

Because risk taking is a component of human development leading, hopefully, toward mastery and higher levels of development, the dilemma for drug abuse prevention approaches is how to support the positive aspects of exploration while simultaneously reducing or eliminating life-endangering risk taking involving drugs. Just because drugs are ubiquitous in our society, one cannot assume that drug use is an expected outcome of adolescent experimentation with lifestyle.

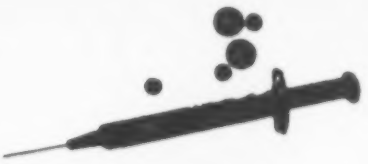
In reviewing intervention programs for adolescents, David Murray and Cheryl Perry state that drug use meets certain personal and social needs of adolescents and that prevention efforts need to explore what drug use means to teenagers so that alternatives can be developed by the adolescents to meet their own needs.

Adolescence is recognized as a time of great physical and emotional change—a time when a person has to learn to cope with pain, as a poet or teenager might put it. Experimentation with a wide range of behaviors and lifestyles is typical, as is a great concern for body image and the physiologic changes taking place. This narcissism is both a potential cause of drug abuse and a clue to designing potential prevention programs—programs that help adolescents come to understand themselves. We can capitalize on this by using approaches that help them realize that other kids have the same mixed-up feelings and concerns about the changes they must face and let them know that their drug use may make them unattractive or unpleasant to be around. It is also important for them to learn about the discipline and deprivations that their sports, rock and movie idols experience to achieve their status, in contrast to how some of them live after they have achieved acclaim.

School-Based Prevention Programs

Some of these principles have been incorporated in school-based substance abuse prevention programs. In 1984, when the National Institute on Drug Abuse reviewed research on such programs,[1] six basic approaches were identified: drug abuse education and affective education as educational modes; alternative programs; psychosocial approaches (resistance strategies referred to as "social inoculation") and personal and social skills training; and cognitive-developmental training, which focuses on physiological reactions to smoking experimentation and user perceptions. (This latter approach is fairly new and results are not yet available.) These prevention programs were conducted primarily in junior high schools and focused on the use of tobacco.

The drug education programs of the 1970s only disseminated in-



A desire for independence based on achievement is one of the strongest protective factors against drug abuse. . .

formation, usually "fear arousal messages," and were particularly unsuccessful. They lacked credibility, and results indicated increases in the level of drug use by program participants. Affective educational programs designed to meet the children's social and emotional needs and to train them in decision-making skills (values clarification, analysis of consequences of behavioral choices and identification of alternative behaviors) did not provide them with specific skills to resist pro-drug pressures. Research indicated little or no effect on levels of drug abuse. These findings suggest that traditional educational approaches were too narrow in focus.

The same fate was true of alternative programs, which did not focus on drugs per se but on community projects intended to reduce alienation and to provide young people with opportunities for recreation, socialization and informal education. Such programs had little or no effect on actual levels of drug use, although the programs provided other benefits to participants.

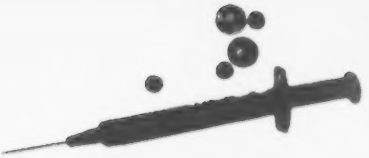
The psychosocial approaches provide a better conceptual framework. These interventions, while all school based, differ in who delivers the message (a classmate, older peer, teacher), the methods of teaching specific techniques for resisting social pressures (role play, modeling) and the use of social contracts (commitments not to use drugs). Some programs emphasize the development of general coping skills, some are substance specific and others are presented within the context of comprehensive school health programs.

Those that teach techniques to resist pressures to use drugs—the "Say No" strategy, among others—are frequently called social inoculation programs, a term which can be misleading because it implies that one "shot" will provide lasting immunity. Research suggests that booster sessions and other types of reinforcement are necessary. Evaluation of the social inoculation and social skills training programs to prevent drug abuse produced similar results: They reduced onset of drug use at statistically significant levels, but in many cases results were confounded by methodological and analytical problems.

Points To Keep In Mind

In intervention research, children are at varying stages of development—for cognitive and psychosocial reasons, they may not be able to comprehend or apply health or drug messages to their own lives. They are also at varying stages of autonomy affecting drug use—in their use of medicines, the presence of alcohol, tobacco and other drugs in the home and the influences and availability of psychoactive substances in the community and at school. We need to learn how to communicate with children at these various stages and according to their individual needs. For example, Patricia Bush reports that children tend to develop their attitudes and beliefs about medicines and abusable substances by the time they are 10 years old. This is rarely reflected in strategies used in drug abuse prevention programs. Health promotion research is beginning to provide models for prevention programs. From such research, we have learned that any approach that ignores the child's developmental stage of comprehension—and the fact that the child's comprehension of health information may lag behind other cognitive areas—will not be productive.

Prevention programs also need to respond to the values of adolescents: independence versus slavish adherence to peer pressure as it replaces parental authority; health and attractive body image when children are vulnerable to fears about the rapid changes in their bodies and moods; and natural highs from physical and mental experiences that support the development of competence, skill and maturation. One should always question interventions—whether for prevention or treatment—in which developmentally regressive demands are placed on young people with drug abuse problems, as this runs contrary to the adolescent's developmental needs to develop critical judgment and independence.



The family may prove to be the most enduring point of prevention or intervention.

Drug abuse prevention and intervention studies outside the school are rare. Interventions oriented toward families tend to select participants based on their having at least one parent or sibling with drug-related problems. Little research has been done regarding other potentially high risk youth, such as infants exposed to drugs in utero, children in high risk family environments or who exhibit developmental difficulties, single teenage mothers and their children, school dropouts and unemployed youth. These populations include a high proportion of minority youth. Special prevention efforts targeted on persons with predisposing genetic, biologic and developmental risk factors are also needed.

A prejudice also exists based on social class. Research to prevent mental health and substance abuse problems among low socioeconomic populations targets such areas as environmental influences, family management, failures in parenting and failure of the child to develop along a maturational trajectory leading to competence and economic stability. However, families of higher socioeconomic status can also face these same problems, and research on these families should not neglect the family and focus on adolescent peer groups without asking why a child may select certain friends and influences while rejecting others.

Training children regarding the use of abusable substances is a sensitive issue. Children in families with a member who abuses alcohol tend to dislike alcohol because of the effects they experience. Such children do not initiate use early, yet they later tend to develop dysfunctional use patterns when their adult lives become stressful. Children in families who are introduced to moderate alcohol use initiate use early, frequently in the presence of their parents, and tend not to develop dysfunctional use patterns. One implication we need to know more about is the degree to which families with moderate use patterns train their children to develop self-regulatory habits regarding alcohol use and help them avoid the problems associated with alcohol consumption or drug use.

Parents have looked to the media, to law enforcement and to other people's children for the cause of and solution to drug problems. However, the findings are consistent: The family's pattern of alcohol and drug use, together with parental child care practices, are significant influences leading young people into acceptance of drug use in their environment. The important impact of the parents is on the development of the child's personality, which in turn influences the child's choice of friends.

The family may prove to be the most enduring point of prevention or intervention. Peer influences, as hazardous as they can prove to be in adolescence, are focused on the adolescent's short-term rather than long-term goals, which means that school-based programs are important, but not a comprehensive solution. We must use all avenues to help our children develop the ability to think about the future, to help them seek a future worth having. We can do this by helping them develop skills and perceptions that give them hope, competence, independence and a good feeling about themselves, for without these, drugs provide a very enticing way to feel good, if only for a moment. ■

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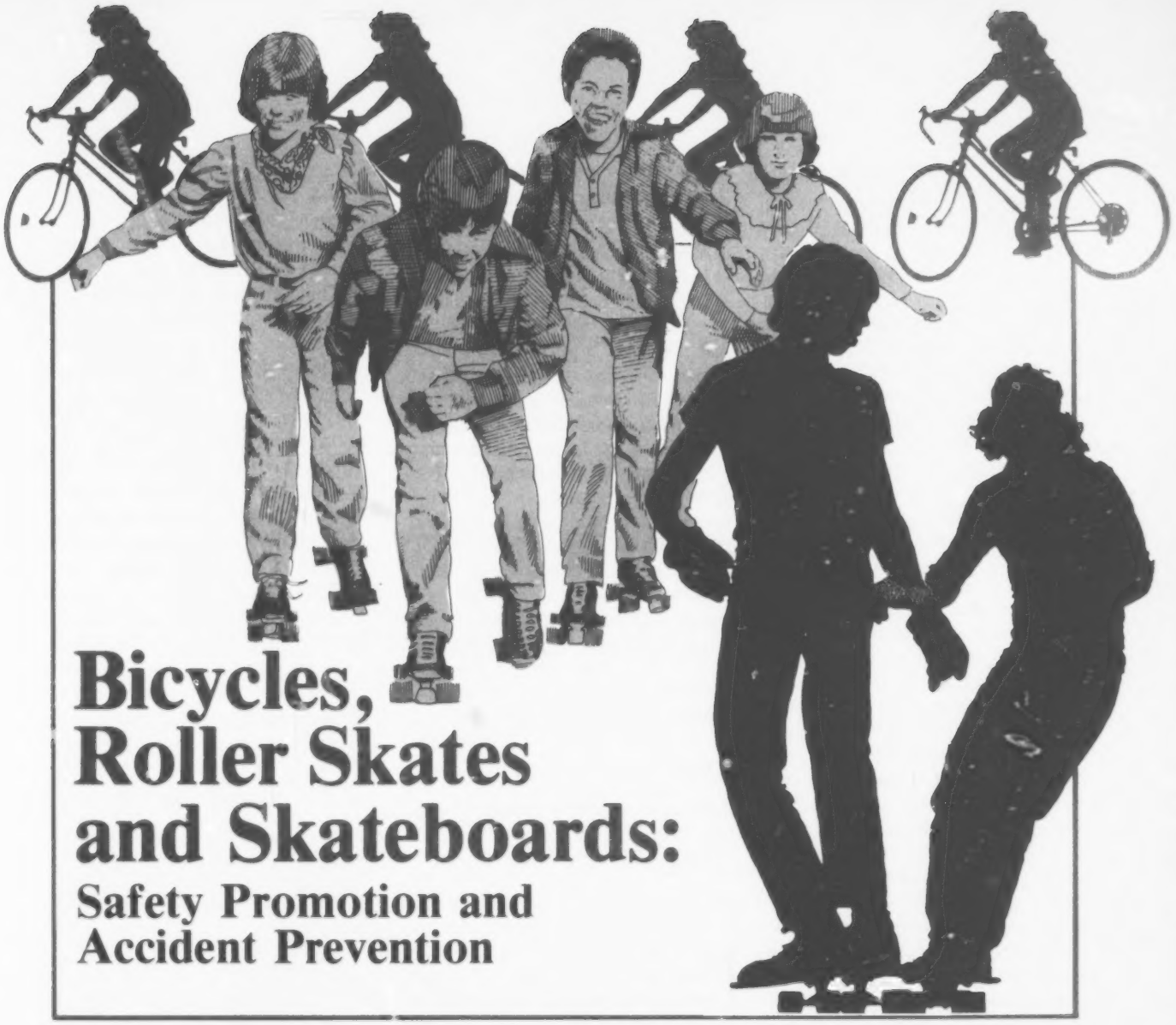
[1] L.D. Johnson, P.O. O'Malley and J.G. Bachman, *Use of Licit and Illicit Drugs by America's High School Students 1975-84*, National Institute on Drug Abuse, DHHS Pub. No. (ADM) 85-1394, Washington, D.C., U.S. Government Printing Office, 1985.

[2] C.L. Jones and R.J. Battjes (Eds.), *Etiology of Drug Abuse: Implications for Prevention*, NIDA Research Monograph No. 56, DHHS Pub. No. (ADM) 85-1335, Washington, D.C., U.S. Government Printing Office, 1985.

[3] C.S. Bell and R.J. Battjes (Eds.), *Prevention Research: Deterring Drug Abuse Among Children and Adolescents*, NIDA Research Monograph No. 63, DHHS Pub. No. (ADM) 85-1334, Washington, D.C., U.S. Government Printing Office, 1985.



Bicycles, Roller Skates and Skateboards:

Safety Promotion and Accident Prevention

by Phillip M. Wishon and Marcia L. Oreskovich

Accidents cause severe injuries in countless numbers of children every day, and they represent a major pediatric problem in the United States. Accidents, which are responsible for more than 50 percent of childhood fatalities, are the main cause of death in children over the age of one year.[1] Among children aged one through 15, accidents may account for as many as one-fifth of all hospital admissions and one-third of all hospital emergency visits. In addition to cycling, growth of roller skating and skateboarding by many young people has also produced a clearer understanding of the dangers associated with these forms of recreation.

Few things that we teach children parallel in importance an awareness of safety and an attitude of accident prevention. This article examines pediatric accidents involving bicycles, skateboards and roller skates, emphasizing prevention and offering recommendations for the safe utilization of these devices.

Transportation and Recreation

Cycling is regarded enthusiastically by practitioners as an efficient, enjoyable, silent, non-polluting, health-giving and economic mode of

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transportation. The National Safety Council estimates that there are well over 100 million bicycle riders in the United States.

According to the U.S. Consumer Product Safety Commission (CPSC), bicycles remain the largest source of recreational injuries. According to the latest figures available from the CPSC—the National Electronic Injury Surveillance System of the United States (NEISS), 1984—more than 556,000 bicycle injuries in 1984 were serious enough to require treatment in hospital emergency facilities (see Table 1).

NEISS data also indicate that 28 percent of all injuries related to bicycle riding occur to the head and face area—types of injuries that are the most potentially life-threatening. Head injury is the most common form of trauma for which children are admitted to hospitals, and reports indicate that the single most common cause of head injury among children is bicycle accidents.[2] Head injury in childhood is not only the leading cause of death within the broad category of trauma, but it may also trigger many subtle changes in the child.[3] In 1980, about 1,200 persons died from bicycle-related injuries, including 410 children in the 5- to 14-year-old age range.[4]

Up to the age of 12, about 90 percent of all bicycle deaths occur when a child darts into traffic from a driveway or fails to obey a stop sign.[5] Virtually all of these deaths involve the collision of a bicycle with a motor vehicle. Indeed, the CPSC reports that 60 to 70 percent of all serious bike accidents occur at intersections. More than 60 percent of accidents are caused by reckless cycling and loss of control, including double riding, inability to brake and stunt riding. Higher rates of accidents are associated with younger children, and the majority of accidents occur close to home.

The most common injuries of juvenile bike riders involve the bicycle spoke and occur primarily when children are passengers on the rear fenders. Typical injuries sustained are abrasions, strains, sprains, severe lacerations and abrasions of foot and ankle, as well as fractures of the leg.[6] Girls may sustain lacerations and abrasions of the labia minora/majora when riding boys' bikes. Riders are also at greater risk for injury when using "high rise" handlebars rather than conventional models, hand brakes rather than foot brakes, or an inappropriate frame size. Mechanical or structural defects of bicycles account for about 20 percent of children's bicycle accidents.[7]

Choosing A Bicycle

It is extremely important that the bicycle be the appropriate size for the child—a bicycle purchased for a child to "grow into" increases his or her risk for injury. The following guidelines for purchasing a bicycle are recommended by the American Academy of Pediatrics:

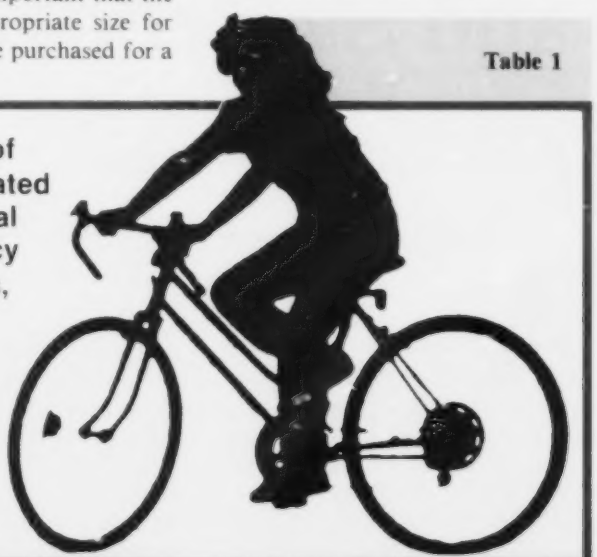
- The intended rider should be present so that the bike can be properly sized.
- The child should be able to grasp the hand brake levers comfortably and easily apply sufficient pressure to brake the bike.
- The rider should be able to place the balls of both feet on the ground when seated on the bicycle.
- There should be approximately one inch of clearance between the crotch and the center bar when the child straddles the bike with both feet on the ground.

Cycling Safety

Instruction in the proper techniques and rules of cycling will set the pattern of lifelong use. Betz offers the following suggestions for

Table 1

Number of Injuries Treated in Hospital Emergency Facilities, 1984



Bicycles	Roller Skates	Skateboards
556,700	86,200	19,300

Source: National Electronic Injury Surveillance System of the United States, Washington, D.C., U.S. Consumer Product Safety Commission, 1984.

teaching children how to ride bicycles safely:

- Familiarize the child with brake usage, steering, handling and balance.
- Require the rider to demonstrate competence in using the brakes to stop quickly; riding without wobbling on a path one meter wide; stopping and dismounting without falling; and riding in a straight line close to the curb.
- Point out routes to and from school, friends' homes and other locations that avoid dangerous terrain or heavily traveled streets.
- Establish "home rules" for safe riding. These would prohibit any bicycling after dark, in bad weather or in heavy traffic; or riding barefoot, with passengers or in restricted areas.
- Reinforce the rules of the road to children as they become proficient riders—cycles are subject to the same rules that apply to vehicular traffic.
- Encourage older children traveling in congested areas to wear protective headgear.
- Insist that children inspect bicycles regularly to ensure that they are in safe working condition.
- Teach children to ride defensively.[8]

Protective Equipment

The importance of wearing protective headgear has been stressed by a number of researchers.[9] Schultz suggests that parents encourage the wearing of protective headgear early on, then peer pressure may enforce its use later.[10] It is recommended that helmets be constructed of a hard synthetic, fit snugly and be lined with shock absorbing material.[11] The wearing of long sleeves, long narrow pants and gloves is also recommended. Children who object to wearing protective clothing place themselves at greater risk for serious

injury from a bicycle accident than children who dress for safe cycling.

Accidents during the evening hours are often caused by an insufficiently equipped bicycle or poorly lit roadways. Bicycles used after dark should be equipped with battery- or generator-operated illuminating devices, and with reflectors that can reflect light originating from any direction. Since 1976, new bicycles are required by CPSC regulations to have front, rear, pedal and wheel reflectors when they are sold to consumers. Wearing clothing that reflects light or to which reflecting strips have been attached is also recommended.

Cyclists should avoid carrying packages if it interferes with safe control of the bicycle, but a bike basket or rack or a backpack may be used to carry objects safely. To ensure optimal maneuvering and braking, the rider should always operate the bicycle with both hands on the handlebars.

Finally, it is recommended that child care advocates support the operation of bicycle clinics that promote bicycle safety. Children who attend these community based clinics and comply with the guidelines they learn there are more likely than other cyclists to enjoy the pleasure of safe, injury-free biking.

Roller Skating

An increase in roller skating injuries in recent years is associated with the growing popularity of this activity. A 1980 *Gallup Youth Survey* found roller skating to be the fifth most popular sport among adolescents, ahead of tennis and skiing. In 1980, almost 50 million Americans were roller skating, and NEISS data indicate that this figure continues to increase. The fact that merit badges are now awarded for proficiency in roller skating by both the Girl Scouts and Boy Scouts attests to the increasing popularity of this sport.

Like its counterpart the skateboard, the roller skate is an inherently unstable device. Modern skates are designed for speed and maneuverability. They are heavier than skates used 10 or more years ago, and their new, smoother-rolling polyurethane wheels are larger and contain sophisticated bearing systems to further improve roll. These factors, added to that of human error, have produced a striking increase in roller skating injuries, especially because the sport enjoys a growing participation by inexperienced skaters.

In 1984, there were more than 86,000 roller skating injuries that were serious enough to require treatment in hospital emergency rooms (see Table 1). According to the NEISS data, about one-third of roller skating injuries are fractures; contusions and abrasions, and strains and sprains, occur at the rate

of 26 percent and 24 percent, respectively. While a majority of injuries involve the wrist, injuries to the elbow and ankle also occur with some frequency. Although roller skating injuries are more common in the upper extremity, lower extremity injuries tend to be more severe and require surgery more often.[12]

A number of factors—including skating experience, surface texture, skate type and quality and protective equipment—have an effect on the type and severity of roller skating injuries. Inexperienced skaters tend to be less skillful, wear inferior equipment and fall incorrectly, leading to more injuries.

The predominance of injuries in the upper extremity can be predicted because most inexperienced skaters attempt to "break" their fall by placing their hyperextended wrist out to the front, side or behind them.

Certain "advantages" of hard rubber toe stops are literally the downfall of the young, inexperienced skater, because they result in an effective but sudden stop that leads to instability and injury.

Irregular riding surfaces contribute to about one-fourth of all roller skating injuries.[13] The admission of more than 75 percent of the injured roller skaters interviewed in one study to a feeling of sudden, unexpected increase or decrease in speed, which caused a loss of balance, suggests changes in terrain elevation.[14] This loss of balance then led skaters to fall, usually backwards, onto outstretched upper extremities.

Safety Recommendations

Use of top quality equipment is a must for all roller skaters. The condition of the skate is associated with either poorly fitting skates, faulty toe stops or the absence of toe stops on the front of the skate. With no toe stops to halt momentum, the skater has to perform a high-friction "T-stop" maneuver not easily accomplished by novice skaters.

Roller skating injuries could be greatly reduced if skating was limited to controlled environments specifically intended for such purposes. These settings would require a uniform set of safety rules, pre-use equipment checks, the use of full protective gear and controlled skating surfaces. In addition, instruction on skating techniques involving turning, stopping and falling could be provided. In general, skaters are less likely to experience an injury-sustaining accident if they are familiar with the terrain on which they skate; if they restrict their skating to sparsely congested areas; and if they use protective equipment such as knee and elbow pads and rigid wrist splints.

Skateboarding

The latest sports fad to cause an alarming number of injuries to children is skateboarding. According to the American Academy of Pediatrics' Skateboard Policy Statement (1979), between 1973 and 1977 there was a 30-fold increase in the number of injuries sustained. The growing number of skateboard enthusiasts is now well over 20 million. Interest in skateboarding has been sustained by the introduction of urethane wheels, which allow better skateboard control.[15] Accordingly, the number of skateboarding-related injuries remains high.

There were approximately 30 times as many emergency room visits for skateboarding injuries in 1977 as in 1973, while the number of skateboarders rose 150-fold during the same period. According to the NEISS data, 46 percent of the injuries are to youngsters aged 10 to 14.

The average time of skateboard ownership before the occurrence of an injury-producing accident has been estimated to be between 14 and 15 weeks[16]—which is simply not enough time for most individuals to become accomplished with the handling of such an inherently unstable device. Only during puberty, when motor skills required for skateboarding reach a peak, does sufficient skateboard control for safe operation become possible.

Skateboarding Injuries

Fractures—which are the most common type of skateboard-related injury—occur in about one-third of all cases. According to the CPSC, fractures of the forearm and wrist, the most common sites for skateboard fractures, occur when a skateboarder falls forward onto an outstretched hand. The ankle is the second most common site for fracture. While freedom of ankle movement is essential for skateboarding, protection at this site is not generally sought. Other common types of skateboarding injuries are contusions or abrasions, and head and abdominal injuries.

Very few skateboard-related injuries are sustained from collisions between skateboards and their riders. They are usually the result of a fall by an inexperienced rider traveling at speeds faster than the rider's ability to manipulate direction and acceleration.[17] One out of every three accidents occurs when skateboarders strike irregularities in the riding surface and lose their balance. Protective equipment has not usually been worn by the victims of most skateboarding accidents.

Safe Skateboard Operation

The most promising way to avoid many skateboard injuries is to require that all skateboarding be done on clear, smooth surfaces not available to motor vehicle or pedestrian traffic. According to the CPSC, irregular riding surfaces account for about one-third of skateboarding injuries due to falls.[6] Skateboarders should know the area where they will be riding and check it out for holes, bumps, rocks and any debris before riding.

Skateboards are not toys. They require complex skills, and training programs by competent instructors should be encouraged. Special training should include the proper methods of falling (crouch, relax, hug arms and roll). Participants should be dissuaded from attempting stunts requiring skills that exceed their level of proficiency, and they should be advised to skate only in areas set aside specifically for this purpose.

The inadequacy of gloves and knee and elbow pads as protection against fractures must be stressed to skateboard participants. However, while such protective equipment as closed, slip-resistant shoes, helmets and specially designed padding may not fully protect skateboarders from fractures, they can reduce the number and severity of cuts and scrapes and are therefore recommended. Long-sleeve shirts and longlegged pants can provide added protection.

Before using their boards, riders should check them for hazards, such as loose, broken or cracked parts; sharp edges on metal boards; slippery surfaces; and wheels with nicks and cracks. Some boards are rated for the weight of the intended user. The skateboard should be the proper size for the rider, be made of sturdy materials and be purchased from a knowledgeable dealer.

Adult supervision is a necessity for all skateboarders under age 10. Skateboard parks provide ideal facilities. Skating surfaces at skateparks are designed for safety and are usually cleaned of debris several times a day. The park is monitored for rules violators and for possible safety hazards. Spectators are kept in galleries where they cannot interfere with skaters or be injured by a loose skateboard.

In addition to these safety considerations, the following guidelines are recommended to reduce the number and severity of skateboarding injuries:

- Use proper equipment at all times.
- Refrain from skateboarding on wet surfaces or without proper lighting at night.
- Attempt difficult maneuvers only after mastering the basic skills.
- Never hitch a ride from bicycles or other vehicles.
- Always complete warm-up exercises before skating.
- Emphasize control of the skateboard rather than speed.
- Stop skating when fatigued.

There is no greater promotion of a child's health than regular, rigorous activity. In whatever recreational activity they become engaged, young people need to be aware of potential hazards, and they need to establish attitudes of safety. It is important that children think about what they are doing and about the consequences of their behavior. It is also important to let them know that the use of judgement is expected and that caution must be exercised. When children learn these things early on, we can have faith that they will conduct themselves in ways that reduce the chances of serious injury-producing accidents. ■

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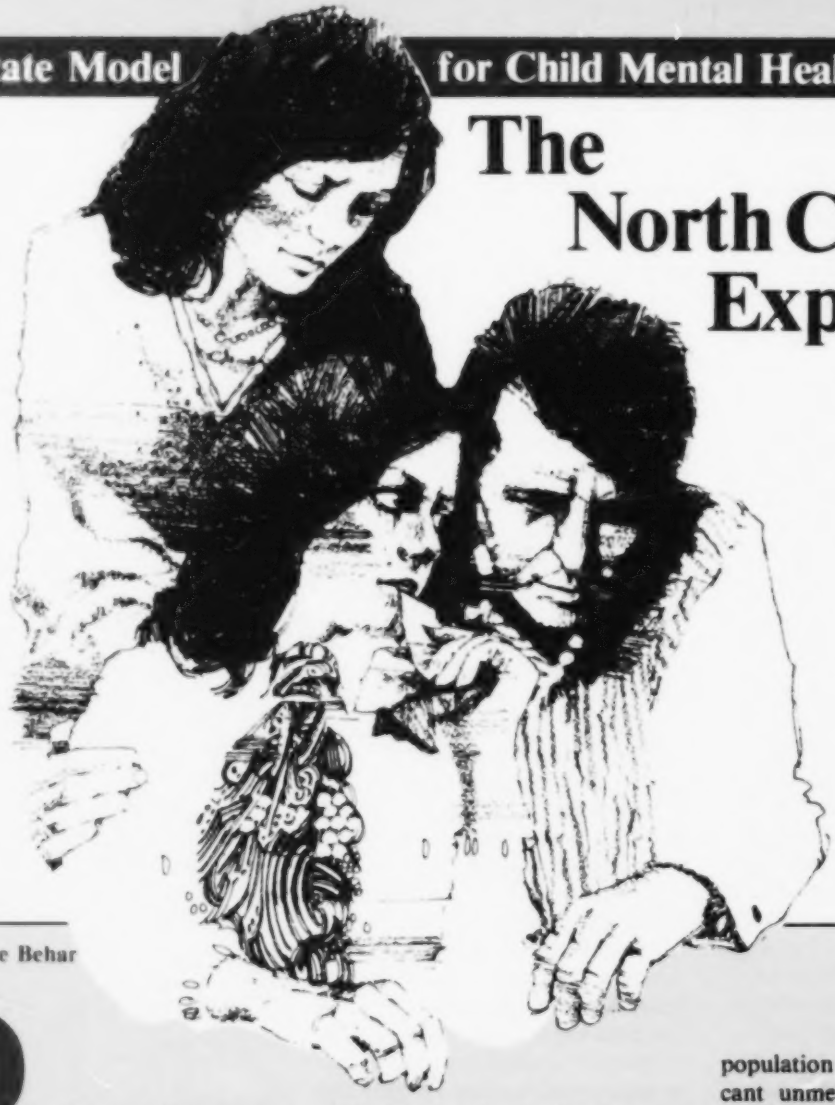
A State Model for Child Mental Health Services:

The North Carolina Experience



by Lenore Behar

Over the past five years, the State of North Carolina has developed an integrated system of services in local communities for seriously emotionally, mentally and neurologically handicapped children and adolescents who are also violent and assaultive. The system for this most difficult-to-serve population has been developed under the leadership of the Division of Mental Health, Mental Retardation, Substance Abuse Services of the Department of Human Resources, in combination with all of the child-serving agencies in the state.

The impetus for the development of these services came from the settlement of a class action lawsuit against the state, Willie M., et al. vs. James B. Hunt, et al., filed in 1979. The lawsuit involved four minors and "all others similarly situated" who had been denied appropriate treatment and education. At the time the lawsuit was filed, the four minors were in state institutions—three in training schools and one in a psychiatric hospital. Sufficient evidence was gathered in the year following the filing of the lawsuit to document that this particular subpopulation of children had significant unmet treatment and educational needs, and the state negotiated a settlement.

As part of the settlement plan, the state agreed to provide the plaintiffs with appropriate treatment, education, training and care suited to their needs, including community programs to provide less restrictive settings when appropriate. The state also agreed to conduct a survey to

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identify all other children in the state who might legitimately belong to the class.

The state looked upon the settlement as an opportunity to develop experimental systems of services and as a significant challenge, recognizing that the agreement represented a blueprint for an ideal service system that, if successful, could be applied to other populations of children in need.

A detailed process of defining this group of children—referred to as the "Willie M. population"—was developed, and the community mental health programs took responsibility for organizing the assessment process. An independent committee reviewed each case and certified those who met the clearly defined, stringent criteria.

Characteristics of the Population

Now, after more than five years, approximately 1,900 minors have been certified, with approximately 1,200 active cases at any given time. An analysis of the first 1,000 cases revealed that the majority—89 percent—are male, and the group is about evenly divided between white and black. Seventy-eight percent are between the ages of 12 and 17, with 55 percent aged 15 to 17.

At the time the diagnostic forms were completed, 47 percent lived at home, 24 percent were in a detention facility or training school, and 16 percent in a child care institution, group home or hospital. Additionally, five percent were in foster care and nine percent in other living arrangements. Fifty-one percent of the children had been found guilty of a criminal act. Nearly two-thirds were functioning below an I.Q. range of 70-84. Of the 651 children in public schools, 56 percent were classified as seriously emotionally disturbed or multiply handicapped.

The Development of the Service System

Implicit throughout the early course of the lawsuit and in the negotiations around the settlement was the understanding that many of these children's needs were thought to revolve primarily around the need for behavioral change, which was expected to result from their receiving appropriate treatment. Although the role of the mental health agency was to provide leadership in program development, it was important to keep in mind that these children's needs cut across almost all agencies. The failure of previous services to these children stemmed from an absence of treatment and education programs to meet individual needs; a lack of linkages to various agencies or services systems; and attitudinal problems on the part of professionals regarding the "treatability" of this population.

A basic set of philosophical assumptions was developed which specified the characteristics of a responsive system of services for the Willie M. population:

- A system of services ranging from highly restrictive settings to settings that approximate normal family living is needed to rehabilitate those youngsters.
- Children are best served close to their own communities to maximize the possibility of family involvement and to allow for reintegration of the child into his or her natural environment.
- To deal effectively with these children, the full continuum of care must be in place; discreet components, whether of the more intensive or the less intensive variety, standing along, will fail.
- The system must provide for linkages among the various components within the system, as well as to services from other child-caring systems.
- There must be flexibility in funding and decision-making to allow the movement of children through the system as their needs change, and backup services and respite services must be available on a 24-hour basis.
- There must be a management structure so that shifts in funds and staff are possible to allow for the movement of children, and there can be no admissions criteria or admissions delayed to program components.
- Individualized treatment and educational planning, with broadly defined case management as the backbone, is essential.

State funds for five areas, or systems, of the state were allocated in 1982. In 1983, the entire state, or 16 systems, was funded at a budget of $22 million per year to serve approximately 1,100 children. In 1985 the budget and class size seem to have stabilized at $26 million for 1,200 children, at an average cost of $21,667 per child.

In addition to the continuing obligation to identify and evaluate potential class members, each system is expected to develop the capacity to provide specific services, individually or more likely in combination, based on the individual needs of the clients. These include comprehensive case management services, outpatient diagnostic and treatment services and in-home services as needed; special education within the local education agency and in an out-of-school setting for those children needing a more restrictive setting; training in life skills, prevocational or vocational preparation; residential treatment services and specialized foster care; and supervised apartment living or monitored independent living for older youths. The systems are also expected to provide emergency services; recreation programs and support services such as transportation

for the child and family; and respite services for children living with families.

These services are provided by the area mental health programs separately or jointly with other public agencies, or they are purchased from private providers.

The major focus of treatment and education is in a community based setting. Clearly, treatment in an institutional setting may be appropriate for a small number of children who need the highly specialized services available only in such a setting. Juvenile justice training schools, however, are not considered to be appropriate settings for the provision of needed treatment services.

The service needs of each child are identified and an individual habilitation plan is developed by the case manager under the supervision of the clinical director of the area mental health program. The plan, which is reviewed every 30 days, identifies existing services as well as those that must be created to meet the child's needs. The educational component is developed by the local education agency.

The case manager, who is responsible for 12 to 15 clients, also reviews the plan in community planning conferences with representatives of agencies and other appropriate individuals who are, have been or may be providing services and support. The case manager also advocates for the child in court, in school and in the treatment settings.

Moving from Individual Needs to Systems Planning

Based on its current population and reasonable projections of the needs of class members to be identified during the year, each system should have necessary components in place or "on the drawing board." If possible, there should be flexibility in funds available to shift into needed components, and there should be some funds in reserve in order to contract for specialized services, as needed. In order for such planning to occur, the systems managers must have a mechanism in place to receive input from case managers on their clients' changing needs.

A decision-making management structure, with a master plan and planning committee, is necessary to oversee the movement of clients along the continuum as their needs change. This committee has a significant role in identifying underutilized services and the need to expand or create services. To the extent possible, this group should be involved in an ongoing review of the status and needs of each child and be aware particularly of those children likely to need crisis services or a rapid change in services.

Observations on Program Development

Now that the earliest funded programs have been in operation for five years and the latest for almost four, a systematic evaluation of the state's effort is beginning, based on data collected over the past three years. In addition to the information that will evolve from the evaluation, several observations can be made at this point that should be useful to others involved in program development.

The most essential point to be made is that seriously behaviorally disturbed children *can* be served in community based programs. Given the nature of the population in question—seriously disturbed, assaultive children—there were initial misgivings among many professionals, decision makers and citizens about whether community based services could or should serve this population. The response seems to be extremely positive at this point, but with the clear understanding that the North Carolina model works to the extent that a) a wide continuum of services is in place; b) a management system is in place to keep the continuum flexible and responsive; and c) a case management system exists to develop the service plans and oversee the implementation of those plans for each client.

Data collected in 1982 indicate that there were approximately 150 Willie M. class members in the five training schools. The training schools were considered not to be appropriate settings for these children, and as community services were developed they were removed. The most current figures—from December 1985—indicate that this population has decreased to 40 youths. Of these 40 youths, probably half of them remain because programs in their local communities have not reached the level of program/staff maturity to provide well for them. The other half could be considered as representing a substantial risk in community based programs. However, this latter number—20—is less than two percent of the 1,200 active cases and .003 percent of the 640,000 children in the state between the ages of 10 and 18.

It is most important to note that in addition to moving class members out of training school, the influx has also been virtually eliminated, ranging from one to three class members per month. Being a class member does not place the child above the law, and commitment to training school is an option open to the court. However, as community programs have developed, it is clear that in the majority of cases, judges are using those program options.

Other secure programs for the most seriously disturbed class members are the four state psychiatric hospitals and several private hospitals, one re-education center

and two secure non-medical settings in local communities. The hospitals provide short-term diagnostic services and crisis stabilization, and in almost all cases the use of these settings is considered to be appropriate. At any given time over the past six months, there were approximately 30 class members in all psychiatric hospitals. The re-education center was developed to provide long-term treatment, primarily for the Willie M. population, and serves 24 adolescents at a time; currently, 20 are class members. The two secure local programs are part of local Willie M. systems of services and together serve 25 youths.

These 75 children being treated appropriately in secure settings are less than six percent of the class members or .01 percent of the 10- to 18-year-olds in the state.

Although some of the very seriously impaired class members continue to require intensive services within the community based system, others considered to be untreatable or poor treatment risks have made substantial progress, moving to less restrictive, less intensive and less expensive services. For example, Charlie was identified as a class member at age 12, while he was in a state hospital. He had a history of rage reactions, during which he hurled objects with sufficient force to damage walls, mirrors and other people. Although he made substantial progress in the hospital treatment program, discharge plans were thwarted when his seriously disturbed mother married a man who professed not to like children.

Thus, Charlie moved to a group home and attended a day treatment program. He had supervised visits with his family once a week, and over a 4-month period, the visits have been extended to three to four full days and nights and are only partially supervised. He and his stepfather are growing to like each other.

Gradually, Charlie has moved from day treatment to a self-contained special education class. He has learned sufficient self-management techniques to control his rage reactions or to ask for help when he feels he cannot manage by himself. His family, including his brothers, and the program staff recognize his continued need for support, structure and acceptance when his self-control doesn't work. Such episodes are decreasing.

Charlie continues to live part time in the group home. His activities are becoming more normalized—he belongs to a Boy Scout troop and plays on a soccer team. His case manager continues to "run interference" for him with the scout leader, his coach and his family.

A second important observation is that by using an individualized service plan approach, a child can be provided appropriate treatment within a system of generally used services, with additional services "wrapped around" the child. In other words, such services as day treatment, vocational training, group living or respite care can be individualized but can serve children in groups nonetheless, as long as some highly individualized services can also be provided to meet special needs. The important issue is that regardless of the administrative system from which the child comes, an individualized plan for the most part eradicates that background—children who have come into the Willie M. programs from the juvenile justice system do not usually require different services than those who have come into them via special education or mental health routes. A troubled child is a troubled child needing an individualized treatment approach, regardless of the agency that last served him or her.

Another important value of the individualized service plan is that it is developed external to any treatment or service program. The plan is essentially developed outside of the system in which the services are to be provided, thus producing what would seem to be a more objective or "purer" statement of short- and long-term needs and how these should be met. That is, a service plan developed within the context of a program by program staff would stem from what the program could or could not provide. However, with the external approach, the case manager does not have to fit square pegs into round holes: He or she can advocate for modifications in programs or for new services rather than settle for what is already in place. The capacity to plan creatively has allowed case managers to feel as though they are making valuable contributions not only to their clients but to the expanded manner by which services are delivered.

It is interesting to note that many such services provided with flexible purchase of service funds can be far less costly than "traditional" services and yet be critical to the child's progress. Examples might be the purchase of supervision and on-the-job training that allows a youngster to work in a barbershop and learn a marketable skill; the development of supervised apartment living for a young mother and her new baby to provide her psychological support and training in care of the newborn; or the purchase of piano lessons to enhance a musical talent and, consequently, enhance a child's self-esteem. All of these services would be combined with counseling for the child and family and special education and/or other services.

This discussion leads to the third observation: Case management, which has been broadly defined in the North Carolina model, has been perhaps the most essential unifying factor in service delivery. In its most

positive sense, case management has emerged as the element of planning and coordinating that has held together the workings of all the agencies concerned with the child. It is the energizing factor that has propelled the service plan into the reality of service delivery, the advocacy strength that has sustained a commitment to each child and an optimism about each child's capacity to change. This type of case management appears to be a critical factor in bringing children and families into the service system and in keeping them involved with the system—and the system with them. Most importantly, the case managers have been the strong force in designing and obtaining appropriate services for their clients.

As systems of services have developed, several "problem areas" have emerged, areas that would seem to generalize to other populations of troubled children, as well. For example, there appears to be a strong tendency to remove children from their natural environment with the belief that effective treatment for children with serious problems can only be accomplished in a residential setting. For some children and families, this is certainly true. However, the North Carolina experience indicates that residential services are over-utilized for children and families, who, in the long run, would do better not being separated. Historically, very few programs have allowed for intensive and extensive full day programming, leaving the child to reside at home as a substitute for long-term residential treatment. Such services, combined with intensive family services and a 24-hour, on-call system, do seem to avoid separation for many children and families.

A second set of circumstances that has historically led to family separation is an intense family crisis where a "cooling off" period seems indicated, or where separation for a longer term seems necessary to accomplish treatment goals that cannot be addressed while the crisis continues. For some situations, the use of residential treatment may be necessary; however, intensive in-home crisis stabilization services certainly have shown considerable promise in keeping children and families together. For some families, the addition of respite services or day treatment may add to the effectiveness of such treatment.

A second major "problem area" in providing services to older adolescents is the importance of helping them to become employable, which is essential to their independence as well as to their self-esteem. Many seriously troubled adolescents have serious academic problems, as well as emotional/behavioral problems; many have a history of unsuccessful and unpleasant school experiences, and they usually have no pre-vocational or vocational skills. These youths are most likely to be the last considered for apprenticeship employment or for on-the-job training, and even when they are willing to continue in the public education system, they are apparently also the last considered for vocational education services. In addition, they are not viewed positively by vocational rehabilitation services, for they do not meet the criterion of showing promise of being employable.

Working out such employment problems has taken a one-to-one approach, involving cajoling employers and running interference for the adolescents, as needed. However, a more systematic approach is needed; a public policy must be effected to add the important dimension of employment to the policies mandating special education and treatment for troubled adolescents.

The Department of Education has recently begun to address these issues and has placed priority on research, demonstration and service programs that help seriously disturbed adolescents make the transition from school to work. Hopefully, this policy focus will yield positive models and serve to raise the awareness of professionals and employers of the importance of vocational success for this population.

Finally, little attention has been paid to the services needed by troubled adolescents who also abuse alcohol and/or other substances. Many mental health or juvenile justice treatment programs profess to have little skills with which to treat them, while those programs that accept such clients consider the abusive behavior as symptoms of other psychological problems. Such programs, however, do not usually address the addictive nature of the "symptoms." Alternatively, treatment techniques designed to apply to adult drug abusers do not take into account the psychological or social development of adolescents that makes such adult approaches unlikely to be successful with many youths. Although the programs that seem to be successful with most of these adolescents have combined the best strategies of each approach, awareness of these program models is not widespread. Dissemination of effective program models for this group of adolescents is important, as is the development of new models and further evaluation.

Conclusion

There is much to be learned from the model developed in North Carolina that can be applied to other populations of children and to other geographic areas.

At this point, five years has seemed sufficient, even given the break-

neck pace that pervaded all aspects of program planning and development. Substantive evaluation any earlier most likely would not have yielded a sound picture of what stable and mature programs can provide for seriously disturbed children. Those evaluations are timely now. The value of the preceding years rests in the lessons learned about the problems and successes that occur in widescale program planning and development, including the attitudes that must change about children for community based programs to succeed; the range of services that must exist and be coordinated for children to be served well in communities; the recognition that individualized service plans can supercede the administrative classification of children and lead to appropriate services for them; and the importance of broadly defined case management as the cohesive element in a system of services.

The implementation of a high quality, comprehensive system is costly, of course. Funding of services to seriously disturbed children has historically not been a federal or state priority—nor a priority of society in general. Documentation of effectiveness in treating the most difficult to serve of these children might perhaps raise interest in funding such services. Clearly, this very difficult population will not disappear. These children represent for society a pay now or pay later opportunity. ■

Moving Through the System: A Case Study

Over a 3-month period, parents and friends had noticed a dramatic change in Rita. The "successful" 17-year-old who had been doing well in school began skipping classes and not completing assignments. She appeared alternately frightened and hostile, and she sometimes seemed not to notice when friends approached her. At home she became withdrawn and slept for unusually long periods during the day. Her formerly meticulous, fashionable appearance changed and she looked messy and dirty much of the time. Rita also developed rigid diet habits and became very religious, professing to have become a Buddhist. Her parents sometimes found her in the middle of the night sitting on the living room floor in a trance-like state. Although they suspected that she was using drugs, they could not substantiate this.

Rita's parents took her to a psychiatrist, who diagnosed her as schizophrenic. He was able to stabilize Rita through a combination of medication and a structured full-day treatment program, which included a home visitor to help her get ready for the day and to escort her to the program. Rita received educational and vocational services as well as individual treatment. Supportive services were provided to the family to help them understand her problems and ways of helping her.

The milieu of the day program was structured to address specific aspects of her treatment plan. For example, Rita would practice responses other than withdrawal to frightening situations. She participated in an "after school" recreation program that focused on her learning to use leisure time, and she developed a talent for photography. Tutoring two nights a week helped her to maintain an appropriate academic level; evening recreational activities were supervised by a staff person. She slept at home. Twenty-four hour emergency services were available in the home, if appropriate and necessary, and counseling was provided for her parents.

At this point, several months later, Rita continues to attend the day treatment program. Most of her evening activities are not supervised by program staff, especially those with her family and her small group of high school friends. Her success in day treatment and after-school social activities has led to a plan for her to return to high school for the fall term. She will continue daily contact with a staff member, and this support will be assessed as she progresses.

Both individually and with her family, Rita has requested in-home emergency services several times a month, all considered to be appropriate. She and her family are encouraged to continue this support, as well as parent counseling, until Rita is stable in her home and school environment. Although relapses may realistically be expected to occur, Rita, her family and staff seem to work well enough together to "ride these out."

Rita's case illustrates several salient features of the continuum of care concept. As the child progresses in treatment, one goal is to move toward less supervision and structure. A second goal is to move toward more "normal" activities, such as the child getting to the day program on his own or with his family's help, spending part of a day in "normal" school, using a community recreation program and eliminating the evening program. As children tend to progress in these areas at different rates, modifications can be made as needed.

Parents and Mental Health Program Leaders:
Working Together in Kansas

by John VanDenBerg and Richard Donner

What role should parents of children and adolescents with severe emotional problems play in getting community based services established in their states? How should state and community mental health program directors involve parents in developing a service system? In Kansas, parents and mental health program leaders are seeking answers to these questions in their efforts to make community based services for seriously disturbed children a reality.

The Kansas efforts are funded by the National Institute of Mental Health under the Child and Adolescent Service System Program (CASSP). This initiative is designed to ensure that a focus on services for children and adolescents with severe emotional problems exists in state mental health authorities, and to encourage states to develop continuums of community based services for this population.

Previous to CASSP, Kansas, like many states, had little available, other than outpatient care at a community mental health center or 24-hour care at a state mental hospital, to meet the needs of severely disturbed children. This lack of ser-

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vices can be catastrophic for a family with a child who needs more than an hour a week in a therapist's office and yet should not be placed in a state mental hospital far from the support of family and friends. Families should have access to a good basic continuum of community based care for children and adolescents with severe emotional problems that includes such services as crisis counseling, home-based services, day treatment and therapeutic foster care.

The population to be served, as defined by the State of Kansas, includes children and adolescents who exhibit severe behavioral, emotional or social disabilities that consequently disrupt their academic and developmental progress and family and/or interpersonal relationships, often to the point that they are at risk for out-of-home placement or are in placement; have disabilities that cannot be attributed solely to intellectual, physical or sensory deficits and that have continued, or are likely to continue, for an extended period of time; and frequently require intensive, well-coordinated treatment delivered by an interdisciplinary team involving the family, courts, education, mental health and other family service agencies.

Through CASSP, states are encouraged to involve parents in developing service systems for this population. State administrators in Kansas first tried to do this by locating groups that advocated for children and adolescents with severe emotional problems. Unfortunately, out of almost 30 advocacy groups for children in the state, none focus specifically on this group. The next step was to locate a parent of a child with severe emotional problems to serve on a statewide advisory council on services for these children. This was done, and while it proved beneficial, something was still lacking: input from a large group of families. The Office of Child and Adolescent Mental Health Services then contracted with the School of Social Welfare at the University of Kansas to develop a more comprehensive effort to reach parents.

The Family Input Program

Jane Knitzer has estimated that there are more than three million seriously disturbed children and adolescents in the United States, and that two-thirds of them do not get the mental health services they need.[1]

Parents of these children have not fared well in a system that is confusing and gives them little assistance in finding needed services. Many find no help in dealing with their child and often those who do have to face blame and harassment—despite the fact that parents play such a pivotal role in their child's life. They are usually the first to identify their child's problems, and they know the complexity of the problems their child has to deal with; they are the only ones who have enough total information to see the child in a nonfragmented way; and most important, they have to live daily with the impact of their child's difficulties.

Why, then, aren't parents more involved in a positive collaborative relationship with service providers?

With the widespread acceptance of early psychoanalytic theory, which emphasized the parents' (particularly the mother's) influence on the development of emotional problems in children, parents came to be seen as the source of the problem and as a barrier to the solution. The family systems theory, which developed during the 1950s and 1960s, later targeted the family and its transactions as the cause of a member's mental illness. While these theories pointed out the importance of bringing professionals back into communication with the family, the result of their application continued to engender guilt and alienate families from professionals. Although some mental health professionals currently view families as less of a causal agent, many of the "old" attitudes still prevail among service personnel. Often, the relationship between parents and professionals is one of treater and treated rather than one of collaboration and support. It seems, then, that the issue of why parents aren't more involved with professionals isn't "with" the parents but rather "how" the service system involves and engages them.

The Family Input Program, which is based on the notion that parents of emotionally disturbed children can be engaged in a nonblaming way in their child's treatment, views parents as the real "experts" regarding their children's needs. It is a variation of previous work done since 1978 by Don Bushell and Stephen Fawcett et al.,[2] who developed methods of involving consumers of human services in the decision-making process. Their work showed that consumer input can improve the services for a given population by identifying and advocating for the priorities they define. In addition, the information can be used by administrators and policy makers in defining and resolving service gaps.

The Family Input Program provides a forum for parents of children with severe emotional problems to meet together in a supportive way and decide what actions they might take in advocating for a

particular issue. Held in community halls, churches and other "neutral" places throughout the state, the meetings are conducted by a representative from the state agency who serves as facilitator.

The program began in the spring of 1985 with a series of three meetings, each attended by about eight parents. During the meetings the parents developed a questionnaire that identified their views of their children's needs and their perceptions of services and professionals. Parents felt that, for the most part, professionals were understanding in dealing with them and their child's problems. From their answers on the questionnaire, and from their response to the initial meetings, it became clear that it is possible to engage parents of children with severe emotional problems, and that they do know what their children's needs are and are willing to work with professionals to find solutions.

Based on the positive results of the pilot project, Family Input meetings are now being organized in five other communities across the state.

The first step is to locate parents to invite them to attend—not an easy task. Since most parents have had contact with schools, mental health centers, local child welfare offices and private providers, professionals at these sites—who have received written explanations on why the state agency wants to meet with these parents—are asked to contact parents and obtain their permission to have the state facilitator get in touch with them. The meetings are also advertised in the newspaper, and notices are put up in laundromats, grocery stores and other prominent places.

The sessions follow the same general format. At the first meeting, the facilitator explains the state agency's need for their input and offers examples of how parents are the real experts on their children. He or she explains that their comments are being recorded and that they will be transcribed and brought to the next meeting, when they will have an opportunity to validate or revise their remarks. Throughout the meeting, the facilitator is careful to emphasize that the agency will use their input in a productive way.

At a second meeting, parents are given the summary, their comments are added, and the facilitator makes arrangements to provide a copy of the final report to the group members.

Impact on Parents

For many parents, the Family Input session is the first opportunity they have had to meet others with similar problems and they often express a desire to continue meeting. In these cases, the facilitator might suggest establishing a support group, or he or she will help connect them to established advocacy groups or to sources for information.

Long after the pilot project, parents in the initial working group continue to assist each other and provide mutual support. At a Kansas CASSP conference last fall, one parent—the mother of a 16-year-old mentally and emotionally disturbed child who had spent many hours in counseling with him—offered her perspective on the experience:

"Through a Family Input meeting we met some other parents of kids that were like ours, and to my amazement, I found out we weren't all by ourselves. There was somebody else out there saying, 'This is the pits. This is without a doubt the most horrible mess,' and not feel bad because I wasn't a bad mom or his dad wasn't a bad dad or that the other kids were crummy or that our family was a really screwed-up mess. After we started talking we found we felt the same way. They understood how it felt and that there wasn't any place to go, that we as parents didn't even know who to call and ask. It was wonderful.

"So we have maintained this little group. We still haven't progressed a great deal but we are hoping we can progress to the point of having some sort of a group where we can hold ourselves together and still get some action. Some action for the parents and some action for siblings within a family. We aren't bad parents. These things happen and it's an unfortunate thing, but we parents are tough and need to be included. We need to know what is happening. We need to feel like somebody cares, that we're not just out there to pay the bills or that we're going to go away. I don't know one of us who is just going to hide away or slip underneath the carpeting. We're going to be there and we care what happens. Until people in the community can accept this and realize that we are out there the situation is not going to get any better for that child or for that family or for us parents or for anybody else."

Other parents have approached the local mental health association and Families for Mental Health to

start a children's chapter. After an article about the possible formation of the chapter appeared in the newspaper, a parent received more than 100 phone calls from other parents of emotionally disturbed children.

Several sets of parents have become involved in public speaking and education regarding children and adolescents with severe emotional problems, and a group of parents now reviews state plans and grants for programs for this special needs population.

The Family Input process enables parents to contribute to the mental health system in many ways. Once a list of needs is identified from parents' input, policy makers and administrators can use the information to help them make informed decisions about services to fund or deliver for this population, and they will know they will be supported by those receiving the services. The Family Input process may also serve to shift the service provider's perceptions of and relationships with parents in such a way that parents may become an important resource, which will strengthen families' abilities to meet their needs. In addition, this process can lead to empowerment of the whole family, which, hopefully, results in improvement in the quality of family life. Finally, children with severe emotional problems and their families may have the chance to access available, appropriate and nonfragmented services. In the long run, this will have great ramifications not only for these children and families but for the entire mental health movement.

Impact on Agency

From the agency's standpoint, important lessons on involving parents in the development of services have come out of the initial Family Input efforts. First, parents offer a perspective that simply cannot be obtained elsewhere. Each academic discipline tends to train its graduates to look at children in different ways, and often the only ones who see the child as a whole are the parents. For example, one mental health center clinician in Kansas reported on a family who was receiving intervention from six separate agencies, none of whom were in communication with the other.

The equivalent can be true at state levels—state departments of education, child welfare, health, mental health and juvenile corrections may support services that correspond to their policies regarding some of a child's needs. Thus, a natural role for parents emerges: to serve as translators between agencies and to remind agencies that their children must be seen as having multiple needs. Hopefully, this will assist agencies in coordinating their efforts and designing their services around the individual needs of the child.

Second, parents have been involved with many recent initiatives in the Kansas Division of Mental Health and Retardation Services. In addition to reviewing new grant applications and providing feedback on program areas, several parents recently addressed a large conference of administrators representing all of the state agencies that serve children. As parents of children whom the service system failed, they presented a sobering, holistic view that most of the audience had never been exposed to. Happily, their presentation served to motivate service providers to work to solve "turf" issues and improve services. A greater understanding of the very real program needs that these children and families have had emerged from such interactions between agency administrators and parents.

Another advantage to agencies of involving parents in service system development is the clear message given to child advocacy groups that the agency is willing to go to any length to improve services. This message has certainly been given in Kansas. Three major advocacy groups are now committed to helping Mental Health and Retardation Services obtain legislative support for a major funding initiative in 1987. Without such support for new community based programs, it is highly unlikely that any initiative in this area could succeed.

In summary, the influence parents can have on developing services for children and adolescents with severe emotional problems in their states can be greatly enhanced by agencies seeking them out, listening to them and learning from them. In Kansas, the emerging service system reflects the unique input that parents can give . . . as the only *true* experts on their children's needs. ■

1. Jane Knitzer, *Unclaimed Children*, Washington, D.C., Children's Defense Fund, 1982.

2. Don Bushell, Personal Communication, University of Kansas, Department of Human Development and Family Life, 1985 and Stephen Fawcett, et al., "Involving Consumers in Decision Making," *Social Policy*, Fall 1982.

Pregnancy and Birth-Related BRAIN DISORDERS:

Despite rapid advances in obstetric and neonatal medicine over the past two decades, thinking among physicians and patients about the prenatal and perinatal causes of neurologic disorders is still deeply rooted in popular but false theories. Physicians were previously taught that problems during labor and delivery and during the newborn period were the major causes of cerebral palsy, mental retardation and epilepsy. However, a vast data search co-sponsored by the National Institute of Child Health and Human Development (NICHD) and the National Institute of Neurological and Communicative Disorders and Stroke (NINCDS) now suggests that these 19th Century notions should no longer be taught.

Physicians once blamed physical birth trauma from prolonged labor, abnormal position of the fetus and injury from obstetric forceps for the incidence of several neurologic disorders among infants and children. Since then, however, the increased use of cesarean delivery for infants at high risk of neurologic disorders and the decreased use of forceps has nearly eliminated physical birth trauma as a cause of neurologic disabilities.

Still, neurologic and communicative disorders affect 42 million Americans. This number includes 780,000 mentally retarded school-age children, 750,000 Americans afflicted by cerebral palsy and nearly two million people affected by epilepsy.

Because injury during labor and delivery no longer accounts for a high proportion of these neurologic disorders, NICHD and NINCDS appointed a group of experts in obstetrics, pediatrics, human genetics and development, teratology and epidemiology to analyze current data to identify pregnancy- and birth-related events that may account for the continued incidence of neurologic handicap among infants and children. The results of this search appear in the report, *Prenatal and Perinatal Factors Associated with Brain Disorders.** A major source for the findings reported were studies from NIH's Neurological Collaborative Perinatal Project (NCPP), a prospective study begun in 1959 to identify causes of brain disorders.

The group of experts sought to establish risk for later neurologic handicaps among infants who experienced problems during labor and delivery and during the first few days of life. In addition, they searched both prospectively and retrospectively for the causes of these disorders, and recommended areas where the NICHD and the NINCDS should channel further research funds.

Although it once seemed simple to say that a specific event, such as birth trauma or asphyxia, caused brain disorders, data in the survey show that it is nearly impossible to pinpoint a single cause and its effect. Both birth trauma and asphyxia, either alone or together, can cause brain disorders. By themselves, however, these events are not frequent causes of severe mental retardation. The causes of this degree of mental retardation appear to be rooted in genetic or biochemical conditions and infections not related to birth events.

The normal brain's ability to repair or compensate for even major injury during development, combined with the gross and subtle interactions of biologic, social and environmental factors, confounds the task of assigning cause to brain disorders. Among mentally retarded children, for example, it is particularly difficult to disentangle environmental and biologic contributions.

Mild mental retardation—the most common degree of mental retardation—appears to relate not to pregnancy or birth events but rather to social and environmental conditions, including such aspects of maternal lifestyle as poor nutrition, cigarette smoking and alcohol and drug abuse. By increasing the likelihood of both prematurity and intrauterine growth retardation, these conditions are well-documented risk factors for future neurologic disability. In addition, infants—especially premature or growth-retarded infants—raised in an impoverished environment have minimal opportunity for optional neurologic and intellectual development.

The group found prematurity to be the most salient birth-related risk factor for cerebral palsy. Premature infants of low birth weight may suffer from such problems as reduced oxygen, respiratory distress and brain hemorrhage. Thus, problems associated with prematurity may place these infants at high risk for cerebral palsy. Fetal hypoxia during abnormal labor and delivery is a strong risk factor for cerebral palsy only among infants later found to be quadriplegic or severely mentally retarded.

Pregnancy- and birth-related risk factors for epilepsy cannot yet be established. However, newborn infants who show evidence of brain injury in the form of neonatal seizures or later cerebral palsy are at very high risk of developing epilepsy. Epilepsy is one of several problems resulting from neurologic damage, but pre- or perinatal risk factors have not been established for epilepsy alone. The condition oc-

The Causes are Not Clear-Cut

by Leslie Fink

Clay Sculpture Jacque Roland

curs frequently among children who have other neurologic disabilities.

Because risk estimates are merely probabilities, the group also looked for data that could establish frank causes of neurologic dysfunction. However, puzzling differences among individual infants further complicate the task of establishing causes of pregnancy- and birth-related brain disorders. There appear to be thresholds for injury, such as degrees or duration of hypoxia. Exceeding these thresholds appears to result in neurologic damage to the fetus. The thresholds may, however, depend upon the infant's biologic reserves, repair capabilities and exposure to previous damage. Indeed, few infants who experience difficult labor and birth develop later neurologic handicaps; most infants who experience such difficulties develop normally.

As birth trauma becomes rare, asphyxia and the changes in tissue oxygenation and blood chemistry it causes have become an apparent cause of cerebral palsy and the mental retardation that often accompanies it. While indicators of asphyxia, such as low 10- or 15-minute Apgar scores, place infants at high risk for both cerebral palsy and mental retardation, only half of the infants who have low late Apgar scores ever develop neurologic abnormalities. Conversely, results from one study showed that about two-thirds of infants who later developed cerebral palsy had normal 5-minute Apgar scores. Major challenges now lie in detecting asphyxia early and knowing its duration.

Despite their exhaustive review of current data, the authors of the 450-page report conclude that little is certain about the prenatal and perinatal causes of cerebral palsy, mental retardation and epilepsy. Owing to the diffuse lack of knowledge, the group identified important areas for future research.

Heading the list are recommendations for support for basic research on normal brain development. A better understanding of the myriad factors—cell differentiation, migration, proliferation and synapse formation—that play a role in central nervous system development may yield therapies to modify or correct errors in these processes. In addition, lack of knowledge about the mechanisms of brain plasticity and repair make it impossible to ascribe specific abnormalities to any single event, or to predict the consequences of injury during development.

Because genetic and biochemical abnormalities account for most cases of severe mental retardation, better use of animal models will help clarify the mechanisms by which these abnormalities cause the disorder. New technologies, such as gene transfer and enzyme replacement therapies, offer hope in the treatment of many forms of severe mental retardation.

Using thorough risk assessment during pregnancy, physicians are now better able to identify the woman at high risk for a problem pregnancy. Although the ability to identify the high-risk fetus *in utero* lags somewhat behind, progress toward that goal is being made. Understanding the causes of premature delivery and low birth weight, and developing methods of early detection and new approaches to intervention must be obstetric research priorities.

While severe and prolonged fetal asphyxia is the major identifiable cause of cerebral palsy, most children who develop the disorder show no signs of asphyxia at birth. Thus, for most children with cerebral palsy, no cause can be identified. Because hypoxia appears to be progressive, strategies for managing brain edema and reduced blood flow in the newborn must be developed.

Finally, the continued monitoring of trends in neurologic morbidity and mortality through controlled epidemiologic surveys will enable researchers to assess the impact of new detection, intervention and management techniques on neurologic outcome. In this time of rapid development in the neurosciences, these studies will better direct research funds into understanding the prenatal and perinatal causes of disabling brain disorders and treating the infants and children affected by them. ■

Leslie Fink is a science writer in the Office of Research Reporting, National Institute of Child Health and Human Development.

*Copies of the report, *Prenatal and Perinatal Factors Associated with Brain Disorders*, are available at no charge from the Office of Research Reporting, National Institute of Child Health and Human Development, Bldg. 31, Rm. 2A32, 9000 Rockville Pike, Bethesda, Md. 20205.

Report from Abroad

Training the Parents of the Future

by John Madeley

Nyasha Conteh is a trained health worker and a teacher. She looks after a 4-year-old boy and a 2-year-old girl, teaching them the right eating and hygiene habits, playing with them and caring for them. Recently she saved the life of the little boy, who had become weakened by diarrhea. Nyasha sat by him and gave him water through the day and long into the night. And when Nyasha noticed that the 2-year-old girl had a bad sore, she took her to the nearest health center for treatment.

Nyasha is an important friend of the two small children—but then 11-year-old Nyasha is their sister. She is one of a growing number of children in the world who have been given basic training to care for younger children and whose care can mean much to the younger child—even perhaps life rather than death. Nyasha is involved in a program called CHILD-to-child.

CHILD-to-child was developed at the Tropical Child Health Unit at the London-based Institute of Child Health, following a request from the World Health Organization and the British government in 1977 that the unit do something about the 1979 International Year of the Child.

"We know that at any one time, around half of the developing world's younger children are being looked after by older children," points out the Institute's Director, Professor David Morley. "We decided to mount a program that would give older children the knowledge and simple training to help them look after the health of their younger brothers and sisters."

So a new program to help the younger child was born and given the name CHILD-to-child. "The first word is spelt in capitals," says Morley, "to remind us that it is the older child to the younger child." Although the Institute of Child Health developed CHILD-to-child, organizations in developing countries carry it out. Over 60 countries today have their own CHILD-to-child program and well over two million children are involved.

Editor's Note: Inspired by the International Year of the Child in 1979, CHILD-to-child is an international program designed to teach and encourage older children to take a role in improving the health and development of their younger brothers and sisters. In the following article, John Madeley, a United Kingdom journalist specializing in development issues, talks with one of the movement's founders about how CHILD-to-child works and where it is going. His article is reprinted from UNICEF News, *Issue 121/1984/3.*

Further information on CHILD-to-child may be obtained from the Institute of Child Health, 30 Guildford St., London WC1N 1EH, U.K.

The success of CHILD-to-child is in many ways the answer to critics who claim that "International Years" never achieve anything. And it would seem that of a number of programs started in IYC, CHILD-to-child has spread the most widely—even though the resources that have gone into it have been modest.

Initial funds came from the British government's Overseas Development Administration but its support lapsed in 1982; UNICEF then stepped in with financial assistance to ensure that CHILD-to-child continued. The program that began it all is run by one full-time worker, based at the Institute of Child Health in London, and one part-time consultant.

To spread word about CHILD-to-child, the Institute has held a number of workshops in the developing world—in Pakistan, India, Botswana, Brazil and the Philippines, for example. It also produces written material which is disseminated to people in developing countries who may be interested in starting a program—especially schools but also scouts and similar groups. The British Council has also been supportive; it developed a photographic display of CHILD-to-child which has been seen in some 50 countries.

"The workshops have helped to bring together people involved both in health and education," Morley notes. "One of the great problems in health care in many countries is that people in the education and health fields do not communicate well—and yet of course they both have a common concern. CHILD-to-child has proved to be one of the best ways in which they cooperate."

With the help of workshops, printed booklets and advice from the Institute of Child Health, programs have taken off and CHILD-to-child has been adopted as part of the curriculum of a growing number of schools. "The

country programs are all different in some way," says Morley, "and we have no accurate idea of how many children are involved, but it is certainly well over two million. It is our job in the Institute to provide a basket of ideas that can be useful. We now produce about 18 activity sheets, dealing with different aspects of CHILD-to-child.

"Sometimes I visit a country, and they say have you seen our CHILD-to-child program and I didn't know anything about it! But that's fine—we don't want it to be a dependency program. We give advice on how they might do things themselves, but we will not tell anyone how to do it."

"... at any one time, around half of the world's younger children are being looked after by older children"

Children Who Care

The country programs may vary in detail but the basics are the same. The older children involved in CHILD-to-child are usually between eight and 12 and the younger ones between one and five—although the age range can be much lower. The older children are generally trained by a health worker in simple nutrition, hygiene, the use of oral rehydration salts and first aid.

"We are also keen," says Morley, "to see that the older child gives the younger ones a stimulating and loving environment. That is so very important in the future development of the young child."

There are critics who believe that although CHILD-to-child has some admirable aspects, it can also have drawbacks; it might, for example, mean that the older child has less time for play and has to shoulder too much responsibility at too early a stage in life, which might inhibit future development.

"This point is often raised," Morley agrees. "But we should remember that in developing countries very few children have time for play, many are working in the home in some way, and many are looking after younger children anyway. Our aim is to train them how to. We have always made it our objective

Over 60 countries have CHILD-to-child programs and more than two million children are involved.

UNICEF photo by Shamsuz Zaman

that any activity we develop should be fun. We do not want older children to be imposed on in any way.

"We also have to be very careful not to make the children feel they are more knowledgeable than their parents and put them in a difficult situation. Parents very often do not have the knowledge and maybe the ability to learn new ideas about health care as do older children who are in a more formative period of their lives. And we are, of course, training the parents of the future."

An effort is made to use the program to help the parents in acceptable ways. Morley recalls visiting a small home in Ludhiana, north India, that was close to an open drain. "The mother used to lock her two children in before she went to work each morning," he says. "They were found by a community health worker who noticed that the younger child, who was only a year old, was doing very poorly. With the parent's agreement, she got to know the older child—age 4½—and taught her how to feed her younger brother, which within a few months she was doing very successfully."

Governments See Potential

In India, Indonesia, Kenya, Uganda, Tanzania, Botswana, the Philippines, Mexico and Guatemala, CHILD-to-child programs have become especially popular and well-supported. A number of governments have put CHILD-to-child material into their own health and education programs. However, health education is often not a priority in schools because it is not a subject included in examinations—and most schools concentrate efforts on getting students through exams.

An evaluation of CHILD-to-child in several countries carried out in 1982 found that the main problems were a lack of financial and material resources, a shortage of personnel, a lack of materials available in the local language and—in just a few cases—lack of parental cooperation. "Each country tends to have different problems," points out the program's full-time worker, Rhylva Offer.

"We are keen to see that the older child gives the younger ones a stimulating and loving environment."

The evaluation also looked at the chief successes. "The older children realize that it gives them leadership qualities and unleashes characteristics unexpressed before," said the report from India. "Children become more mentally alert and better able to cope with school" was one of the conclusions of the Jamaican report. And, in a very interesting note from Bolivia, "It improves the health of the marginalized child and conscientizes the parents of schoolchildren."

Where does CHILD-to-child go from here? Reaching two million children is fine, but that is only a very tiny proportion of the children of the developing world. "CHILD-to-child now seems to have its own momentum," says David Morley. "I would have thought that we might be moving into a period of more rapid growth, especially as one country sees that the program is

Older children are generally trained by a health worker in simple nutrition and hygiene.

working in another country. It's a great opportunity to use what is an entirely new resource, the older child, for stimulating the younger child."

Teaching older children to understand weight charts is now being considered for inclusion in CHILD-to-child printed material. "If weight charts as a health aid are to take off, then children must get to know more about them," Morley stresses. "We would also like to include more material on children's moods so that the older child can understand signs of frustration and aggression in a younger child. We plan to produce something on bereavement—again enabling the older child to help the younger one to understand bereavement."

He also points to the potential for developing activities such as animal husbandry. "Older children are often left to look after animals; it would help if children could recognize when animals were not well so that they could do something about it."

CHILD-to-child clearly has many strengths, although the cautionary note that might be sounded is that, in some cases, those strengths could become weaknesses. It could mean, for instance, that unscrupulous parents are a little more likely to exploit their older children, making them shoulder too much of the job of caring for the health of infants in the family—and even keeping them out of school to do it.

Against this it could be argued that children in such homes are at risk anyway and that any training given to an older child can only help the younger members of the family. CHILD-to-child is also a way in which a family that has a history of problems in caring for its children can begin to break out of the spiral of uncaring parents neglecting children who grow up to become uncaring parents. ■

". . . we should remember that in developing countries very few children have time for play. . . many are looking after younger children anyway. . ."

Channel One:
An Intergenerational Program at Work

by Margery Allen

In 1980, when Channel One first opened for business in Rochester, Minnesota, residents of the community could be excused for thinking it was a new television station. Now, six years later, Channel One is well known as the food co-op operated by senior citizens and high school students. More than 500 seniors shop at the co-op, and all segments of the community have provided support through fundraising, growing produce, collecting food, working in the store, delivering groceries and other efforts.

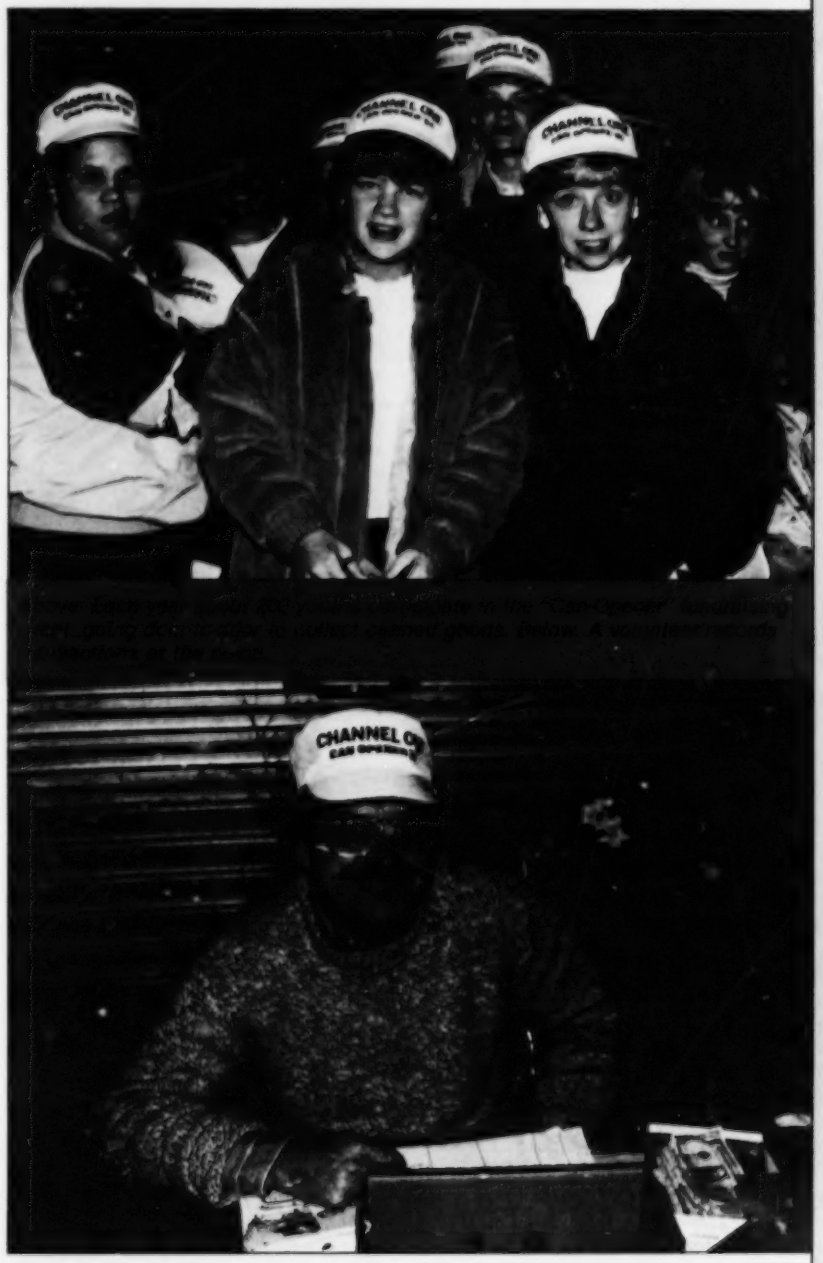
Photos courtesy of Channel One, Inc.

The Rochester project was one of several Channel One efforts originally funded by the National Institute on Drug Abuse. Although the projects differed, all shared the common goal of involving young people in meaningful community activities as an effort to prevent drug abuse.

NIDA provided seed money to states, which then worked with a Prudential Life Insurance Company manager to identify communities to establish a Channel One project. Rochester was selected as a site, and a group of very diverse people was invited to develop a plan—representatives from businesses and social service and youth-serving agencies, members of the clergy, law enforcement officials, school personnel, community volunteers of all ages and students from the three local high schools. After several meetings, which resulted in a dozen suggestions for possible projects, the group selected the Senior Citizens Food Co-op.

One of the first tasks, finding a location, was resolved—after much searching—when the YMCA donated space in an area that had been unused for a while. Carpenter and painter apprentices from the vocational high school built shelves, using lumber donated from local companies, and the Mayo Clinic donated a desk and chair.

Food to stock the shelves was obtained in various ways. Churches, schools and businesses donated canned goods, and the students conducted several fundraising projects —washing cars, collecting aluminum cans and holding a skate-athon, for example—to purchase additional items. They also started a gardening project to raise produce for the co-op. These and similar efforts yielded about 6,000 items by opening day.



A committee composed of students and older citizens visited agencies in the community that provided services to seniors, explaining the co-op to them and asking them to refer those who needed food assistance to Channel One. The older people were also invited to work as volunteers in the co-op in exchange for food.

An open house was arranged with the mayor and Chamber of Commerce, and Channel One was ready

Margery Allen is Executive Director, Channel One, Inc., Rochester, Minnesota.

for business. Only 27 seniors shopped at the co-op during the first month, but customers increased steadily as word of mouth informed other older people that they would be treated with respect and dignity.

More than 375 senior citizens now use the co-op each week. After registering and receiving a card, a shopper selects eight items; such additional foods as bread, fresh garden produce and some frozen foods are considered "free" because they are donated regularly to the co-op. It is expected that an exchange will be made for the food—either time, a product (like brown bags: the co-op uses about 1,200 a month!) or the donation of $1.00 toward the purchase of food.

Although at first the students and elders worked together in the co-op, it is now set up to be manned by the senior citizens, who supervise the food pantry, take home delivery orders, shelve food, weigh produce and otherwise assist shoppers. Students sit on the Board of Directors and are very involved with fundraising projects. They also deliver groceries to homebound seniors and plant and harvest a garden to provide the co-op with fresh produce.

One of the original goals was to have the older people pass along or exchange skills with the students for food. That hasn't happened yet, as the trust level of the older people using the co-op needed to be established before moving into that level of sharing. Now, after several years of operation, it may be possible to move in that direction.

Intergenerational sharing, however, has come about in other ways. In her statement to the Senate Select Committee on Aging, which was collecting testimony on the benefits of young and old working together toward a common cause, 18-year-old Laura, a board member, referred to her work with Channel One as one of the most influential factors in her life.

Volunteers prepare to stock shelves at the co-op.

"I just never had the chance before to really meet older people," Laura told the committee. "When you're my age, you don't get the opportunity to sit down and talk with people who have lived a lot longer than you. At the co-op, the atmosphere is very comfortable. It's easy to strike up conversations.

"I work with an elderly man who is now a very good friend of mine. I think one problem is that people usually don't have the patience to get to know one another and to appreciate what the other has to offer."

"I look at myself very differently now. This experience has added so much more to me, to my understanding. It has opened my eyes and changed my life. I think a lot of elderly people are lonely. Some don't get out of their homes very much, and when we deliver groceries to them, many want us to just sit and talk and share some time with them. It is something different for them to look forward to, and it means a great deal to us as well."

The statement of an older volunteer at the co-op, 66-year-old Doris, who accompanied Laura to the Senate hearing, provides another perspective:

"Channel One has been a great help to me supplementing my weekly food supply. I have also met a great bunch of people . . . I guess that's the beauty of Channel One. It helps seniors but it also brings people together—the old and the young. I think that's important because youngsters don't have older people to be with usually and this kind of gives them grandparents who care. And you know that the older folks enjoy the young people. They make us feel younger.

"Older people need affection. And most young people can be very affectionate and caring. It makes a big difference in our lives. It is also very rewarding to watch the young people who help the elderly and see how much they get out of it and how good it makes them feel to serve someone else."

Channel One operates with an annual budget of $45,000—and much community support. We believe that it demonstrates what can happen with a little bit of effort from a lot of different people of all ages. ■

Book Reviews

Growing Up Poor

Terry Williams and William Kornblum (Lexington, Mass., Lexington Books, 136 pp., $17.95 hardbound, $8.95 paperback)

Reviewed by Frances H. Jacobs

One finding from *Growing Up Poor* has particular implications for policy makers concerned with youth unemployment: Positive interactions between job-oriented mentors and disadvantaged youths may increase the economic and social mobility of the young people.

This book reports on a demonstration program funded by the Department of Labor, in which 86 disadvantaged youths aged 14 to 16 were employed as research assistants to interview peers and parents and then write life histories to document the experiences of poor teenagers. The nearly 900 interviews took place in four cities: New York, Cleveland, Louisville and Meridian, Miss.

"Disadvantaged" youths, the authors explain, are not merely children with low incomes. They are young people who have learned a sense of dependency rather than independence, whose education and job searches are restricted to areas of industrial stasis or decline, and who have never learned skills prerequisite to successful work experiences. Some of their parents and siblings, although working, may be employed at subsistence level wages.

The authors describe "choices" such youths make when a positive mentor is not present. They are likely to drop out of school and resort to life on the streets. Drug dealing, pimping and crime become a means to street-defined success. As an alternative to a job, a youth may join a "crew" (gang) organized around transactions that will elicit money. The crew's internal division of labor and specialization of functions may resemble a small neighborhood business.

A female school dropout becomes more dependent when she becomes pregnant. She may need the support of family members for herself and her infant. Even if she can obtain a job, it is likely to be at a salary level too low to lift her out of poverty.

The authors note demographic and political factors that have an impact on disadvantaged youths' "screens of opportunities." For example, the recent influx of immigrants and older women into the labor market may lead to a scarcity of legitimate job openings at the entry level. They also discuss briefly some policy issues, such as whether employment policy should be made at a national or local level.

In addition to concerns regarding the authors' conceptualization of the problem and their lack of attention to the issue of youth employment in secondary labor markets, I have other concerns about this book:

- The authors' selection of study groups overweighted poor black youth and underweighted poor white ethnic youth—a group with more absolute number of cases receiving AFDC.
- There could have been greater parity of background among the seven field directors. Interviews were to be supplemented by observations of cultural patterns in the four communities—essential data in the study—and observations are, of course, influenced by the education and values of the observer. Better control of the observers from the top might have resulted in better comparative data.
- The inclusion of about 900 interviews is puzzling, if not excessive. This particular study, based on qualitative methods and apparently encompassing no statistics, is not particularly well served by the large number of interviews. One wonders whether the researchers might have more effectively captured the structure and dynamics of poverty among youth by focusing on a relatively few number of cases within a given context.
- Finally, there were times when I wished the authors would go beyond the specific case to make a controlled comparison. To do less is to provide an uneven understanding of what "growing up poor" means in the four cities.

Given these caveats, the question is whether one can learn about growing up poor by reading this book. It may be useful in its description of inner-city black youths in New York City (with three experienced ethnographers at the study's helm), and it raises some questions about the role of mentors and their impact on youth—an issue that may need to be brought to a public forum once again. From a non-scientific perspective, however, if this book results in one more mentor and/or one less youth in trouble, it has value.

Frances H. Jacobs, Ph.D., is a social science analyst in the Family and Youth Services Bureau, ACYF.

Controlling Stress in Children

James H. Humphrey and Joy N. Humphrey (Springfield, Charles C Thomas, 195 pp., $21.95)

Reviewed by Bernard Brown

The effect of stress on child development is receiving increasing attention. There is accumulating evidence that physical, mental, social and emotional growth are reduced by a continued high stress alert period.

The team of James Humphrey, a pioneer of stress education, and his daughter Joy Humphrey, a child stress management consultant, has produced an excellent guide for parents, teachers and counselors on how to help children control undesirable stress.

The book begins with a superb, highly readable, 18-page discussion about stress. It then proceeds to discuss some basic aspects of child development and how to help children understand stress. This is followed by a chapter on stress in the home and the much neglected area of stress in school, including teacher behavior and test anxiety. The authors also discuss the role of health and fitness.

The last third of the book reviews approaches to helping children control their emotion and fears. They discuss such stress management methods as relaxation, mental imagery, creative movements and meditation and the major products and approaches that have been developed for working with stressed children.

This text is a comprehensive survey that will be of value to anyone who works with children and is looking for new understanding and new methods of meeting children's needs.

These are sound techniques that have been shown to work for many children in both individual and classroom settings. However, there is insufficient warning about possible side effects from using these techniques. Some children, a borderline psychotic child, for example, might be harmed by imagery exercises.

Teachers and parents should be cautioned that for some children with physical and emotional problems, stress management work requires the guidance of appropriately licensed health care providers.

This generally careful book, focusing on activities that can be performed by parents, teachers and counselors, does not mention biofeedback, a major method of self-management that is now widely used for adults and children. When parents and teachers need special help they can turn to health care professionals and educators certified in the use of biofeedback. (These are listed in the register of the Biofeedback Certification Institute of America, 10200 West 44th Avenue, Suite 304, Wheat Ridge, Colo. 80033.)

Despite these caveats, which apply equally to most texts on childhood stress and indeed to most books on education, this book is a good general introduction to a growing area of work with children and would make a fine text for teacher training.

Bernard Brown, Ph.D., is a social research analyst in the Administration for Children, Youth and Families.

The Child Abuse Potential Inventory Manual, 2nd Edition

Joel S. Miller (PSYTEC, Inc., P.O. Box 300, Webster, N.C. 28788, 102 pp., $24.00)

Reviewed by Cecelia Sudia

In the early 1970s, when the problem of child abuse began receiving national attention, it was frequently suggested that we need a test that would clearly identify potential child abusers. Workers would then screen groups, pick out the abusers and retrain them or provide other appropriate treatment. Unfortunately, it was not that easy. Early scales identified too many possibles, or failed to identify some known abusers. Furthermore, proposed programs infringed on the civil or confidentiality rights of individuals who might be identified as potential abusers.

Twelve years later, Joel Milner appears to have solved the first problem. This manual provides all of the background information on numerous studies to insure that the Child Abuse Potential (CAP) Inventory is valid and reliable. It consists of 77 easy-to-read items, which are answered "yes" or "no": For example, "I often feel very frustrated"; "Children should always be neat"; "My family fights a lot." Six dimensions are measured: distress, rigidity, unhappiness, problems with child and self, problems with family and problems with others.

Scoring, which is also available for computer, allows an estimate of faking-good, faking-bad and random response. If these are too high, the test is invalid. A valid test using the cur-

rent scale will successfully classify 90 to 95 percent of known abusers and 85 percent of controls. The scale evaluates only physical child abuse. On neglect and sexual abuse, it does not reliably differentiate, although individuals suspected of these types of abuse score higher than normal. Study on these is underway and interested researchers are invited to cooperate. A Spanish-language version is also available for testing.

The problems of self-incrimination and confidentiality have not changed. However, the scale can be used to identify high risk groups in treatment programs, particularly as a measure of the effectiveness of treatment, and as a screening instrument before employing child care workers, as well as for further research.

★ ★ ★ ★ ★ ★
★ ★ ★ ★ ★

America's Children, Who Cares?

Madeleine H. Kimmich (Washington, D.C., The Urban Institute Press, 112 pp., $9.95 paper)

Reviewed by Cecelia Sudia

The first shift in federal funding and priorities since 1960 was seen in 1982, when the Reagan administration funded major social, mental health and health services programs as block grants to states, rather than as individual programs, and reduced total funding by 25 percent. This action transferred most decisions about priorities to state and local officials and also the responsibility, if more

funds were needed, of acquiring them from other, non-federal sources.

Many groups were concerned that the result of this change would be very detrimental for children, poor families and other politically powerless groups. The Urban Institute has conducted several studies to monitor changes to states and programs, and this report is a succinct recounting of what has happened in regard to programs for children and families.

It is possible that the investigators were expecting a predominately negative outcome. In fact, the title of the report implies such a negative. Nevertheless, the research and writing are even-handed and disclose many positive outcomes. State decisions and state establishment of priorities appear to be responsible to groups in need. Great creativity was exhibited in transferring programs and funding. In fact, this report should be read by state administrators, since it provides extensive examples of the strategies used in 18 states to replace lost federal funds, arrange for intertitle and interblock transfers and revise priorities in the various service areas. In addition, it reviews the consequences of passing the responses down to county level and to changing distributional formulas within a state.

There is also a review of the impact on private agencies. In general, private agencies have been able to replace lost funding, although some programs were dropped and those agencies receiving high proportions of their funding from federal funds were seriously affected.

The emphasis on priorities has meant that "quality of life" programs, such as rat control and removing lead-based paint, have been severely curtailed. Stricter eligibility requirements have reduced the number of families receiving AFDC, Food Stamps and Medicaid, with the result that routine health care may be deferred or transferred to lower quality care. Programs of last resort, such as general assistance and emergency services in health and food assistance, have experienced increased requests, while the quality of available child care is considered to have declined as a result of funding under AFDC child care rather than under social services, which had higher standards for care.

On balance, it appears that while there have been some negative outcomes, the block grants and the transfer of decision-making to state and local levels have had many positive aspects. However, it does not follow that states will be able to adapt to further cuts in federal programs without the possibility of rather serious negative outcomes.

Cecelia Sudia is Family Services Specialist, Children's Bureau, ACYF.

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- Medical Foster Care
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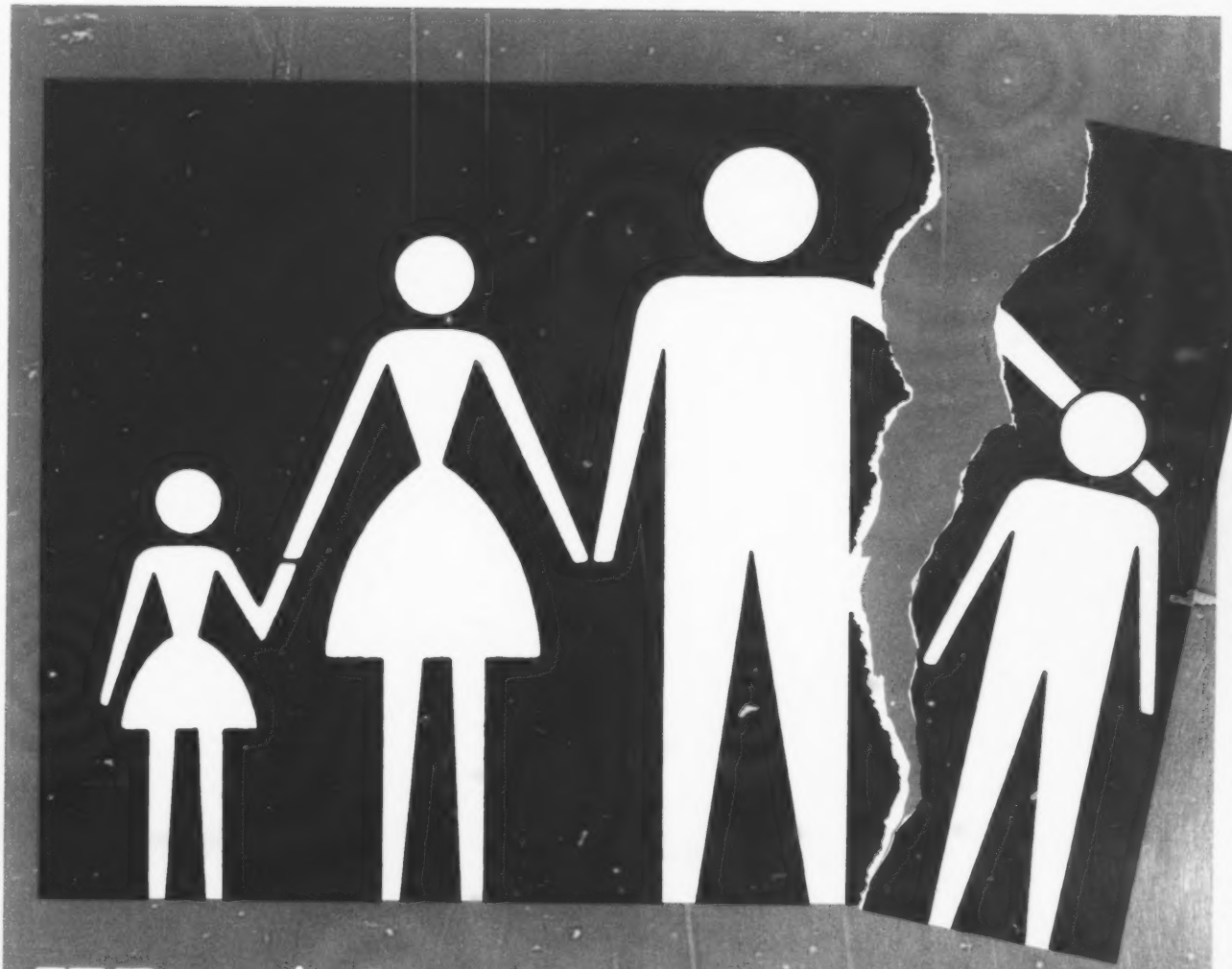

Why Adoptions Disrupt . . .
What agencies can do about it

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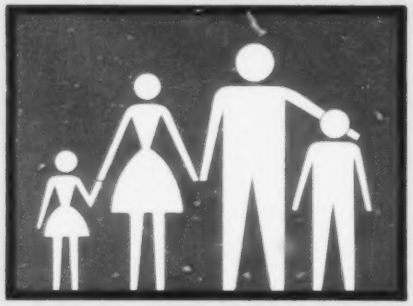

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2 **FYI:** Parent Aide Association . . . Domestic Violence . . . Preventing Sexual Abuse.

7 **Why Adoptions Disrupt And What Agencies Can Do To Prevent It** by Helaine C. Hornby. Findings from a study of more than 200 families with adopted children are yielding valuable insights into the reasons why adoptive relationships collapse and the factors agencies should consider in matching children and families to avoid disruption.

12 **Medical Foster Care: An Alternative To Long-Term Hospitalization** by Patricia H. Foster and J. M. Whitworth. The program model described here, which uses registered nurses as foster parents who work closely with parents of abused and neglected children with acute health problems, is reuniting families, improving parenting skills—and saving money.

17 **The Deaf Child In Foster Care** by M. Teresa Arcari and Beth Gwinn Betman. With a greater awareness of and sensitivity to the special needs of hearing impaired children in foster care, agencies will be better able to work toward permanency planning and avoid needless multiple moves.

22 **KID-ABILITY: Taking Action Against Child Sexual Abuse** by Nayda Rondon. This Girls Clubs of America program, now being expanded to other youth-serving organizations nationwide, aims to increase children's self-esteem and confidence and help them learn how to obtain help in problem situations.

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26 **Missing Children: A Close Look At The Issue** by Howard Davidson. The statistical dilemma and the controversy over media exposure are examined in this article, which also looks at the role of the National Center for Missing and Exploited Children.

31 **Project MAIN: Community Collaboration Benefits Senior Citizens** by Gerald F. Blake. An urban university, a high school and a senior service agency work together to offer food shopping and escort service for elderly and disabled citizens.

35 **Book Reviews:** **Care and Commitment: Foster Parent Adoption Decisions**
Emerging Issues in Child Psychiatry and the Law.

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FYI / Worth Noting

New Resource Centers...The Children's Bureau has awarded grants to create three additional National Resource Centers for Child Welfare Services. The new Centers are:

National Resource Center on Child Welfare Services to Developmentally Disabled Children
Child Development and Mental Retardation Center
Clinical Training Unit
University of Washington
Seattle, Wash. 98195
Mary Richardson, Director

National Child Abuse Clinical Resource Center
Kempe Center
University of Colorado
Health Sciences Center
1205 Oneida St.
Denver, Colo. 80220
Richard Krugman, Director

National Resource Center for Child Abuse and Neglect
American Association for Protecting Children
American Humane Association
9725 E. Hampden Ave.
Denver, Colo. 80231
Patricia Schene, Director

The nine National Resource Centers are part of a comprehensive, coordinated effort to improve child welfare services nationwide. The six Centers established earlier focus on home-based services, foster care, legal consultation, program management and administration, youth services and special needs adoption (see FYI, CHILDREN TODAY, Jan.-Feb. 1986).

Junior League Honored...The Association of Junior Leagues, Inc. is the recipient of the first President's Award given by the Association for the Care of Children's Health, an international organization of pediatric health professionals and parents. The award recognizes the Junior League's "long-standing and significant contributions to quality and supportive health care for children and their families..."

FYI

FYI /Special Report

UN Report Cites Potential for Child Care Revolution

It is now possible to save the lives of up to seven million children annually throughout the world while dramatically and inexpensively improving the health and growth of millions more. A 4-point strategy operating through community-based primary health care could halve the infant mortality rate within a few years.

These are some conclusions of *The State of the World's Children 1986*, a report prepared by the United Nations Children's Fund (UNICEF) that offers information concerning up-to-date scientific advances in the areas of child survival and child development. Published in English, French, Spanish and German, the report stresses the leadership role of political leaders, educators, health professionals and specialists in Third World child care in enhancing the quality of life for millions of children.

Part I highlights mounting evidence from all over the world that indicates relatively simple and inexpensive methods now available add up to the potential for a child care revolution—methods like oral rehydration therapy (ORT), breast-feeding and improved weaning, maintaining vitamin A levels and checking weight gain, preventing low birth-weights and leaving longer intervals between births.

World-wide, demand for vaccines has tripled since 1983 and several nations have doubled or tripled the proportion of their children who are immunized against some of the most dangerous childhood diseases. In total, 40 nations are moving towards the United Nations goal of immunization for all children by 1990. As a result, the number of children's lives being saved by vaccines in the developing world is now approaching one million a year. The rapid spread of ORT is estimated to be saving approximately 500,000 children annually from death by diarrhoeal dehydration—still the biggest single killer of children in the modern world.

The report sees the potential for a revolution in child survival as part of a wider shift in the concept of health care towards "self-help" actions. Because the revolution in child survival does not depend solely on professional medical services and can be put into practice largely by parents themselves, it has the potential to reach the vast majority of the world's poor. But scientific advances are only half the battle, and the report makes a compelling case for social and political priorities that are also needed: "The success of the child-care revolution depends on the commitment of a nation's leaders to the task of informing and supporting millions of parents in becoming effective front-line health workers for their children."

Part II features a collection of notes and quotes, facts and examples, research findings and expert opinion on major low-cost methods of protecting children's lives and growth. The notes are distilled from hundreds of publications in the field, and provide ready access to the most current and authoritative information. Subject areas covered include growth monitoring, the promotion of breast-feeding, family spacing, female education and food supplementation, including the issues of low birth-weight and food fortification.

According to the report, instead of 20 percent of the population, technology has been made available to 80 percent of the people of developing nations because it is geared to working through organized resources with a "social reach" going beyond the usual outreach of the health services themselves. The strategy of mobilizing all possible organizations and channels of communication is being used to put low-cost methods of child protection at the disposal of the majority. An important role in this "social breakthrough" is being played by the growth of the formal education system, the mass media, private voluntary organizations, and the communications resources of organized religion—including the Catholic Church in Brazil, Colombia and El Salvador, Muslim leaders in Indonesia, and Buddhist priests in the villages of Burma and Sri Lanka.

Experience has demonstrated that new ideas about health are put into practice more effectively if a trained health care worker lives in the community, village or neighborhood. In India, there will soon be a total of 600,000 health guides throughout the country, and in Burma, over 25,000 community health workers and 8,700 auxiliary workers have been posted. In Thailand, 43,000 "health communicators" have been trained to bring basic health messages to families in over 90 percent of all villages. In Pakistan, 15,000 traditional birth attendants have been trained in mother and child protection strategies.

The report stresses that the decline in the rate of child malnutrition and deaths in the next few years in nations with a political commitment to put primary health care into practice will accelerate progress toward reducing population growth. When parents have confidence in the survival of their existing children, the report points out, they tend to have only the number of children they want. Thus, such nations as China, Korea, Cuba and Costa Rica that have achieved reductions in child deaths have also achieved the lowest birth rates in the developing world.

Part III is a full statistical section with all-nation figures on nutrition, health, education, population and economic progress. In keeping with the report's central message, statistical tables list world nations in order of their child survival rates.

The report concludes that present knowledge holds out the opportunity to provide, for the first time, a basic minimum protection for the lives and growth of the world's children. But to fulfill this potential, "parents need the support of their own political leaders and of the international community, of the health services and of all branches of government, of the community health workers and the mass media, of the schoolteachers and religious leaders, of the employers, trade unions and the women's movements, and of people's movements in both developing and industrialized nations. If this opportunity is not taken, the 1980s and 1990s will be rightly stigmatized as the generation that presided over the paradox of unprecedented financial and technical capacity with the continued malnutrition, stunting, and death of its most vulnerable citizens."

Copies of *The State of the World's Children 1986* are $19.95 each for the hardcover edition and $6.95 each for the softcover, and can be ordered from Oxford University Press, 200 Madison Ave., New York, N.Y. 10016, or from Oxford University Press Bookshop, 116 High St., Oxford OXI 4BZ United Kingdom. Further information on the report is also available from UNICEF Headquarters, 866 UN Plaza, New York, N.Y. 10017.

FYI /Resources

Parent Aide Group Formed

A national association has been launched by a group of parent aides and parent aide supporters throughout the country to insure the nationwide development of the growing parent aide movement and promote parent aide activities that strengthen families, offer support to parents, and prevent child abuse and neglect. The National Parent Aide Association supports the development of a national network of parent aide programs, especially in states and communities not being served; serves as a clearinghouse for information exchange and technical assistance; and represents the interests of parent aide programs on a national level.

The Association defines parent aides as trained, professionally supervised individuals, volunteer or paid, who offer in-home, one-on-one assistance to parents under stress and to those whose children are at risk of abuse or neglect. The parent aide provides this assistance by devel-

oping a trusting, non-judgmental relationship with the parent and by being a positive role model. Parent aides work to develop parental self-esteem and reduce isolation, strengthen parenting and home management coping skills, improve problem solving and communication skills, enhance understanding of normal child development, and promote utilization of community resources.

The Association is spearheading a number of activities to foster development of a strong national network of parent aide programs. These include compiling an inventory of parent aide programs across the country; publishing a national newsletter; linking experienced providers to programs with expressed needs; developing a clearinghouse; and representing the national interests of parent aide programs to public and private organizations and the media.

Co-Presidents of the Association are Jetta Bernier and Eva Marx. Further information is available from the National Parent Aide Association, 14 Beacon St., Suite 706, Boston, Mass. 02108.

Insuring Child Care Programs

Because child care providers constantly face situations where there is exposure to civil liability, it is important for them to take preventive measures to shield themselves and their programs from possible liability. Maintaining good safety programs, following applicable licensing requirements, and purchasing insurance are essential protective measures for child care programs to take.

The Child Care Law Center—a nonprofit legal services organization that seeks to improve and expand child care services—has developed *Insuring Your Program: Liability Insurance*, a publication that examines liability insurance for child care programs, how it works, what types of coverages are available and required, and how to determine what coverage is needed and adequate. Also highlighted in the 15-page brochure are alternative means of covering liability in the event of a lawsuit, including "homesteading," a procedure available in some states for family day care providers who own their own homes; purchasing a bond; and contracting with parents to limit liability.

The publication advises child care programs to "buy insurance only after careful assessment of specific needs and budgetary constraints, and periodically reassess existing coverage to be certain that it continues to provide adequate coverage, both in terms of scope and policy limit."

Other topics covered include negligence, a discussion of whether homeowner or home-business policies provide liability coverage for family day care homes, liability coverage for volunteers and officers of child care programs, what is not covered under liability insurance policies, purchasing additional coverage beyond the limits of a policy, and determining if a child care center employee is covered under general liability insurance if accused of physical or sexual abuse.

The Child Care Law Center represents individual providers through its network of volunteer attorneys, offers training and educational seminars for both lawyers and laypersons, provides technical assistance on legislative and administrative analysis, and offers advocacy support for improved child care policies on local, state and federal levels.

Some material in *Insuring Your Program: Liability Insurance* was adapted from *A Guide to Insurance for Non-Profits*, a resource for understanding insurance for nonprofit organizations (available at $11.50 per copy from the Consortium for Human Services, P.O. Box 1183, San Jose, Calif. 95108). Copies of *Insuring Your Program: Liability Insurance* are $3.00 each from the Child Care Law Center, 625 Market St., Suite 815, San Francisco, Calif. 94105.

Preventing Sexual Abuse

A national newsletter about preventing the sexual abuse of children and adolescents has been inaugurated by the National Family Life Education Network, a nonprofit child advocacy organization and subsidiary of E.T.R. Associates.

Preventing Sexual Abuse consolidates information about sexual abuse prevention and treatment for parents, educators

and other concerned adults and is designed to be an informational exchange for administrators, crisis volunteers, social scientists, clergy, counselors, nurses, physicians and other professionals. Each quarterly issue will feature an article by an expert in prevention education; reviews about new books, pamphlets and other materials; current legislation and research; and school and community programs across the country developed to prevent abuse. An annotated listing of new resources and a calendar of conferences and training seminars and workshops will also be included.

The first issue highlights an article by Alexander G. Zaphiris, J.D., Ed.D., on sexually abused boys and discusses the underreported incidence of male sexual abuse and exploitation, the identification/casefinding process, and aggressive and destructive behavior patterns exhibited by sexually maltreated boys. It also describes sociopathological disorders characteristic of the adult sexual abuser; intervention and treatment procedures; and measures needed to counteract male sexual abuse, including curricula on family life and sex education for junior and senior high schools and parent and community public awareness projects. Other articles survey Vermont studies on adolescent sexual offenders, effects of intervention strategies on sexually abused and neglected children, acquaintance rape among college students, state statutes related to child abuse and neglect, and a California program designed to prevent the sexual assault of developmentally disabled children.

Subscriptions for the new publication are $18 annually and information on ordering, along with a free preview issue, is available from the National Family Life Education Network, E.T.R. Associates, P.O. Box 1830, Santa Cruz, Calif. 95061.

Assessing Children's Medical Play

Children's medical play in drawings, drama, journals, puppetry and other areas is examined in the monograph, *Medically-Oriented Play for Children in Health Care: The Issues.* The publication is the third in an annual series on issues in Pediatric Mental Health developed by Pediatric Projects Incorporated, a nonprofit corporation that distributes mental health publications and medically-oriented toys to improve psychosocial services for children in health care.

The monograph—which also describes programs in hospitals, clinics, schools and museums—discusses cases in which children's art illustrating medical experiences increased their understanding of their medical circumstances. It also presents research on children's affinity for "disabled" stuffed animals, noting that observations of children at play with animals that have crutches, braces and bandages yield information not readily available with other play items.

Highlighted are examples of the use of medically-oriented playthings to prepare children for hospitalization, treatment, surgery or visits to clinics or doctors' offices. Research is urged on the use of specific toys and on medically-oriented play in general, and ideas are offered for studies to improve knowledge in this field.

The monograph also features an annotated, illustrated directory of medically-oriented playthings that provides a source of ideas for homemade or purchased therapeutic materials and includes anatomically correct dolls, doll patterns, puppets, stuffed animals, toys and games. A bibliography categorizes references by art therapy, dolls, play and puppetry, among other subjects.

Copies of the monograph (#3) are $12.84 each (including postage and handling) and can be ordered from Pediatric Projects Incorporated, P.O. Box 1880, Santa Monica, Calif. 90406.

Dealing With Domestic Violence

Domestic violence damages the lives of the adults involved and has destructive psychological effects on their children, but it is never too late to intervene to help victims of domestic violence. The sooner children are removed from a violent environment and taught to acknowledge their feelings and express them without violence, the better their chances of moving out of the generational cycle of abuse.

This is the hopeful message of *Working With Children From Violent Homes: Ideas and Techniques*, a book intended for social workers, teachers, shelter workers, counselors and others who work with children from violent households. Developed by

Network Publications, a division of ETR Associates, the publication addresses such questions as: What are the symptoms of abuse in children? Who are the abusers and why do women remain in a violent environment? What problems related to domestic violence can occur?

The book lists ideas for helping children from violent homes, including the use of books and guided fantasy, open-ended story telling, art projects and games, and teaching safety measures. Other topics focus on how counselors and child care advocates can approach parents about suspicions that violence is occurring in the home, what agencies to call to determine if a mother can enter a shelter or safe home, and information that is required for admission. A listing of suggested readings and resources for adults and children—including addresses and phone numbers for national and state resources—is included.

Copies of the 37-page publication are $7.95 each and can be obtained from Network Publications, 1700 Mission St., P.O. Box 1830, Santa Cruz, Calif. 95061.

Intergenerational Sourcebook

Growing Together: An Intergenerational Sourcebook is a comprehensive guide to programs and research directed to social service providers, educators, youth leaders, professionals in the aging network and others interested in advancing intergenerational programs and activities. In addition to describing a variety of successful programs, the sourcebook reports on research studies examining the effects of bringing older and younger people together in the same environment, and on children's attitudes toward aging and the elderly.

A joint effort of the American Association of Retired Persons (AARP) and the Elvirita Lewis Foundation, the sourcebook was written and compiled by Karen A. Struntz of AARP and Shari Reville of the Foundation. Lennie-Marie P. Tolliver, Ph.D., former Commissioner on Aging, served as special editor.

The book is divided into five sections: commentaries on the value and need for intergenerational programs and research; reports on research studies; descriptions of intergenerational programs in child care centers, schools and communities; brief summaries of more than 50 unique programs and a list of national organizations involved in intergenerational activities; and annotated bibliographies of curriculum materials, audiovisuals and clearinghouses.

The sourcebook has been distributed to Area Agencies and State Offices on Aging as well as to AARP chapters, state and national organizations and youth-serving organizations, superintendents of instruction in all school districts in the United States, and city, county and state recreation departments. Single copies are also available from the American Association of Retired Persons, 1909 K St., N.W., Washington, D.C. 20049, or the Elvirita Lewis Foundation, 255 N. El Cielo Rd., Suite 144, Palm Springs, Calif. 92262.

A companion publication—*Intergenerational Directory: An Addendum to Growing Together*—which lists, by state, local and state agencies that may have information on intergenerational programs, may also be obtained from the Elvirita Lewis Foundation.

FYI /Training

Family Friends Manual

A manual to train older volunteers to work with severely disabled children and their families has been produced by the National Council on the Aging (NCOA). Developed for use in NCOA's Family Friends projects, the manual outlines the volunteers' role and responsibilities and discusses various types of developmental disabilities and the impact on the child and family.

After a successful pilot project in Washington, D.C. (See "Family Friends" by Ann V. Schmidt, CHILDREN TODAY, Sept.-Oct. 1985), the Family Friends model is being replicated, with support from the Robert Wood Johnson Foundation, in eight metropolitan areas across the country.

In addition to explaining how the volunteer can assist with behavior management, care for the child and introduce activities to aid the child's development, the manual describes the volunteer's role in providing moral support, serving as a role model and helping families gain access to community resources. A bibliography of selected readings is also included.

Information on ordering the Family Friends training manual may be obtained from Family Friends, National Council on the Aging, Inc., 600 Maryland Ave., S.W., West Wing 100, Washington, D.C. 20024.

Why Adoptions Disrupt ...
and What Agencies Can Do To Prevent It

by Helaine C. Hornby

After I had concluded a recent talk on adoption disruption, one agency director stood up and asked, "Why did you sanitize the subject?" I replied that as a researcher, I perceived my job as talking about numbers and that's what I did.

But having interviewed dozens of families and workers, I was also painfully aware of the pre-teen boy who had sexually abused the family's 3-year-old daughter, giving her nightmares she is yet to overcome; the 5-year-old girl who refused to eat in her new home and eventually heaved vomit across the room when forced; the young man who attempted to set fire to the trailer where he and his adopted family lived; the boy who goaded his father to the point that the man slapped him on the face and realized he could no longer go on. These are some of the children whose adoptions have disrupted.

However, I also remember the child who repeatedly vandalized property, yet his father's response was, "Please, just tell me how much I owe you." Or the autistic girl who had resided in institutions for years until her new family provided a home of her own where she is exceeding everyone's expectations. There was also the lad who spent the first several months abusing the family animals. And the boy who was eventually diagnosed as "character disordered," not having the capacity to distinguish right from wrong, and his mother's reaction: "We have made a commitment to him. Even if he winds up in jail some day, we know we will have given him his best shot." Under difficult circumstances, these placements are enduring.

When adoptive relationships, intended to be permanent, suddenly

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collapse, everybody suffers: the child, the family, the caseworker, the agency. Adoption disruption is about the severing of relationships. In our study of over 200 families, a quarter of whom had disrupted adoptions, we did not meet one family who was not deeply remorseful, if not devastated, by this occurrence. Similarly, years later, workers still felt wounded by their perceived failures and searched for answers to what had gone wrong. In fact, one of the surprising findings of our research, which included 58 in-depth interviews with families, caseworkers and administrators, is that in the aftermath of disruption the event is not routinely analyzed with the family or even within the agency. On several occasions our talk was the first time the family had the opportunity to review what had happened.

While disruptions in the first three years of placement occur rather infrequently—less than 10 percent of the time, on average—their effects can be so harmful that the phenomenon has become the subject of much recent scrutiny. The research reported here, which was funded by the Children's Bureau, ACYF, and conducted at the University of Southern Maine, encompassed families in four states served by six agencies, public and private, and examined adoption disruption from the perspective of child, family and agency characteristics.[1] The findings are yielding valuable insights into what variables are significantly related to disruption and what the implications are for practice.

For purposes of our study we defined disruption as any adoptive placement which had been initiated and terminated within a 2½-year period. It did not matter if the adoption had been legalized. We included far more disrupted placements than would have been present in a randomly selected sample because we wanted a large enough group to form comparisons.

By examining the history and background of the children who had disrupted in relation to those who had not, we found some striking differences. Those in the disrupted group were much more likely to have experienced a history of abuse—either physical, sexual or emotional. For example, 86 percent of the children whose placements did not last were known to have been physically abused by someone in their past while 58 percent in the continuing group had suffered physical abuse. Similarly, a significantly larger proportion of children who had been abandoned or neglected showed up in the disrupted group.

The sad reality of these children's pasts manifested itself in many problematic behaviors in the present. Three particular kinds of problems should signal a warning for workers because their presence was highly correlated with disruption: eating disorders characterized as "serious" by the child's worker, including refusal to eat, serious binging, hording food and excessive vomiting; suicidal behavior, including threats and attempts; and sexual behavior characterized as "promiscuous" by the worker. Adoptive families appear to be unprepared, unable or unwilling to deal with these types of behaviors. To the extent they are known prior to placement they should be the subject of discussion and a plan of action developed between agency and family.

While the movement to place older children for adoption has yielded permanent homes for many, our analysis confirmed that of several other researchers: Older children and those who have been available longer for adoption are more vulnerable to disruption.[2]

Some of the most problematic are the children who have lost their ability to trust, to show affection and form lasting relationships. In addition, children in their early adolescence may confuse the normal desire for independence with their rejection of parents in the new adoptive home. For some, adoption is not a believable concept because they hold memories of other significant grown-ups and idealized families in their past.

While the research underscores the need for agencies to make timely, permanent plans for children, there are many children free for adoption right now who are at least as old as the average age of the disrupted group—age 11. While statistically more likely to disrupt, these children nonetheless have every right to permanent homes. We need to bring whatever knowledge we have to bear about successful placements in similar circumstances to the placements of these children. The other key factors, then, in finding homes for older children with special needs are the adopting families and the agency's own practices and services.

The Adopting Families

Many family traits can be measured objectively. Some of the most significant attributes, however, are revealed through personal interviews. Our case record analysis shows that married couples (as opposed to single parents), families with prior adoptive experience, white parents and couples where both partners have an equal commitment to the adoption experience significantly fewer disruptions. Size of the family, age of the parents, income, fertility history and educational background are not associated one way or another with disruption. Similarly, transracial placements appear as likely to succeed as same race adoptions.

Among our six study agencies, criteria for selecting families surrounding age, income and marital status have been liberalized to the point that some consider people up to age 70, income which is marginal (although some draw the line at AFDC) as long as it is stable, and any form of marital status (although some exclude homosexual pairs). These agencies place great importance on the parents' knowledge and understanding of self, their abilities to resolve conflict and the overall quality of the marriage. A positive "we have a lot to give" attitude is a plus, but workers are wary of a save-the-world approach borne of naivete. "Don't think love can conquer all," several parents warned us. "Many of these children are much too troubled." Other important conditions in the home environment are flexibility, a sense of humor and a sense of adventure.

A family's social class and education are significant to the extent that they influence the parents' expectations of the child. Some children do not do well in upwardly mobile families who have struggled to get where they are; the child places too great a drain on family resources and often cannot meet social expectations.

Traditional middle-class families may expect the child to conform in ways not possible. One mother became disgruntled because the child absolutely refused to have a normal breakfast and make his bed each morning. Another consistently would not feed the family dog. Over time these transgressions of family "rules" became bones of contention described as major contributing factors to the disruption.

Naturally, agencies should not reject upwardly mobile or middle-class families, but caseworkers do need to be aware of the pitfalls. They should help parents identify their most basic values as well as the areas of children's behavior that are "non-negotiable." Expectations should be discussed and evaluated ahead of time.

Another important factor is the parents' prior experience with emotionally disturbed children, adolescents and particularly other adopted children. These "tried and true" families are more likely to succeed the second and third times around.

If these are some general criteria for selecting families, what factors should workers consider in matching specific children and families to help avoid disruptions? Some have already been suggested.

Parental expectations. If the family has specific aspirations and expectations for a child, what are they? Intelligence? Physical beauty? Athletic prowess? Love of the outdoors? Aspirations in and of themselves are not bad. It's a question of a child's ability to deliver. One young man who did not do at all well in school loved to tinker with cars. He is doing fine in a home where the father is a mechanic.

Routine and neatness. Some families are bound by tight schedules. When two parents work, for example, there is little flexibility to attend excessive appointments. Some mothers cannot tolerate taking extra time in the morning getting a child dressed or spending longer at bedtime to quiet fears or show extra attention.

Just as in marriage, divergent attitudes towards tidiness can cause serious problems over time. One mother became exasperated because each night her adolescent daughter refused to check her clothes to see if they belonged in the wash or not.

Defensive styles. Some parents can show anger, others hide it. Same with children. Will the new parent and child have a compatible way of communicating and arguing? Can the grown-up resist being brought down to the child's level?

Presence of siblings. The roles of other children in the home must be carefully scrutinized. Will the new child threaten an enjoyed status of another as the oldest, youngest or middle child? How will school relationships be affected? Are the

siblings secure enough to befriend a child who may be subject to ridicule? One family disrupted because the older sister could not accept the boy from the start. While she probably detected some vulnerability in her parents' own attitudes, she made life miserable for them until he was gone.

Ability to plan a course of action. Some of the most successful placements under adverse circumstances occurred when parents knew in advance the challenges a particular child would pose and planned a course of action that included specific behavioral techniques. They took the child on as a challenge and were prepared. Other parents faced problems that may not have been as bad but were caught off guard.

Ability to distance from the child's behavior. Parents have a better chance if they can take some credit for the improvements their children make, but little blame for their failures. Those who internalize the child's behavior as a reflection of their own ability to parent can run into serious difficulties. Witness the mother whose child was diagnosed as having impetigo. She was humiliated and told the doctor he was dead wrong because she sent her children up to bathe every night. She later learned they ran the water but never got in the tub.

Commitment. In addition to the willingness to stand by a child under difficult circumstances, the term commitment connotes an underlying perception of the child as a separate person with a history that influences his or her current behavior. It takes true compassion to look beyond a child's superficial words and behaviors to comprehend his most basic feelings and needs.

The Agencies

We have already indicated that the best thing agencies can do is speed up the decision-making process to the extent it is within their power. Children placed at younger ages and with fewer traumatic losses as they move from home to home are less likely to disrupt. However, agencies cannot afford to short-cut the child's preparation for adoption.

In many disrupted cases, there is insufficient work to help the child gain a true understanding of his or her past. Preparation is needed to deal with the child's memories of both biological and foster families, behavioral difficulties, feelings of loss and rejection and unresolved emotional conflicts. Many children hate and blame themselves for their own predicament. If they cannot move beyond these feelings, they will be unable to love a new family.

L. Chestang and I. Heymann suggest that preparing older children involves clarifying their relationships to natural parents; explaining they are entitled to parents of their own; explaining why the foster parents cannot adopt; and seeking their help in describing what they seek in a family.[3] J. Neilson says that visits to key places such as vaguely remembered homes and schools can help the child remember the past.[4] One girl opened up in a way that was previously impossible when she visited the grave of her grandmother.

In our study of techniques used to prepare children for adoption, we found that the life book was most frequently employed. The book contains photographs, documents and other memorabilia to help construct a history of the child's life. When nothing is available, the child can do his or her own illustrations, using facts drawn from memory and the case record. However, this tool was used in only 58 percent of the cases.

Our review of agency practices showed that disruptions are significantly less likely when the placing agency has custody. We can think of various explanations. Public agencies with custody sometimes contract with private agencies to place their most difficult children. These private agencies may not have the child's complete background and history. Also, they may be forced to move quickly in selecting a home before adequate work can be done in preparing the child.

From the perspective of the caseworkers interviewed, the major cause of disruption involves the special needs of the children and the inability of the adopting families to cope with these needs. About two-thirds of the families requested help from the adoption agency prior to disruption. However, in a majority of cases, the agency did not learn of the problem until two months or less prior to the disruption. And in one-fifth, the agency first became involved at the time of the disruption itself.

In many cases, parents had high praise for the efforts of the workers, many of whom are on willing call 24 hours a day. Difficulties arose when parents thought they were being judged by the agency and therefore withheld problems until they were very far gone. Parents also complained about communicating difficulties to workers and receiving no tangible help. Some became incensed when they thought the agency was undermining their concerns, telling them, "Oh, the child is just acting out."

When agencies do sense difficulties, their most prevalent response is to increase caseworker time with the family and/or the child. In addition, referrals to counseling or therapy are made in nearly half the cases. Few attempted trial separations. While several parents begged for the child to be placed in residential treatment for a period of time, the agencies with the responsibility to pay are often reluctant due to the cost and the fear that the child will never return.

Many caseworkers interviewed thought there was basically nothing they could have done to prevent the disruption. The majority, however, wondered if at least some additional or different interventions might have helped: earlier therapy and individual counseling, and more thorough assessment of the child's needs, problems, history and capabilities. Among the successful placements, preparation of the parents, counseling, help with administrative and legal matters, connecting parents to other adoptive families and careful matching were mentioned as the most influential factors in the agency's work.

Putting the perceptions of the parents and caseworkers together, one sees the overriding need for teamwork in making an adoption succeed. Preparation of the parents, which includes early sharing of concerns, even the discussion of the possibility of disruption, is vitally important. If parents leave the preparation period feeling resentment towards the agency, then a successful placement appears less likely. We have talked considerably about making the right match and preparing the child as well as possible. Once the placement is made, consistent, open communication is necessary between worker and family. As one worker put it, "We want the family increasingly to be able to handle situations themselves." However, this desire has to be balanced with sufficient scrutiny for the worker to help before matters get out of hand.

Many times the best forms of tangible support can come from other adoptive families. Agencies are wise to introduce such families to one another. Some sponsor social gatherings, support groups and educational programs to foster these relationships.

A disrupted adoption indeed causes pain and should be avoided whenever possible. The only thing worse, however, is for the agency never to take the chance because the "ideal" home is not available. For every child to find a permanent home, there will be misstarts. Fifty-eight percent of the children in our study were placed again. The girl who would not eat is now happily situated in another family. So is the boy who aroused such anger in his father. Agencies need to spend more time analyzing their disruptions and learning from them. They also need to work with the families to process the hurt. Just as children can find new homes, some disrupted families have successfully gone on to raise other adopted children. If a disruption does occur, there is pain, yes, but for the child, family and agency there is also still hope. ■

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[1] The study was conducted by Susan Partridge, Ph.D., Helaine C. Hornby and Thomas McDonald, Ph.D. For further information, see *Legacies of Loss—Visions of Gain: An Inside Look at Adoption Disruptions*, Portland, Human Services Development Institute, Center for Research and Advanced Study, University of Southern Maine, 1986.

[2] See, for example, B. Benton, E. Kane and M. Tipton, *Evaluation of State Activities with Regard to Adoption Disruption*, Washington, D.C., Urban Systems Research and Engineering, Inc., 1985 and J. Boyne, L. Denby, J.R. Keltenring and W. Wheller, *The Shadow of Success: A Statistical Analysis of Outcomes of Adoptions of Hard-to-Place Children*, Murray Hill, N.J., AT&T Bell Laboratories, undated.

[3] L. Chestang and I. Heymann, "Preparing Older Children for Adoption," *Public Welfare*, Winter 1976.

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Medical Foster Care:

Although Norman's recovery was complicated by the need for a tracheostomy, his mother, with support from the Medical Foster Care program, was able to take responsibility for his day-to-day care.

by Patricia H. Foster and J. M. Whitworth

With the high cost of hospitalization and increasing federal demands for cost containment and utilization review, new approaches are necessary for addressing the needs of abused or neglected children with severe health problems. Children who are ventilator dependent, require tube feeding or need burn or tracheostomy care often remain hospitalized indefinitely when their biological families are unable to care for them. Typical foster families are not legally qualified or trained to perform the daily treatment and evaluation of children with complex health problems. Yet the usual alternative, institutionalization in a restrictive hospital environment, creates psychological problems, withdrawal of biological parents, hours of nonproductive agency and professional time and expenditure of public funds for high-cost services.

Medical Foster Care was developed by the Children's Crisis Center, Inc., Jacksonville, Florida, as an alternative to hospital "boarding" of abused and neglected children with

An Alternative to Long-Term Hospitalization

acute health problems. Its goals are to reduce inappropriate hospitalization, reduce the length of stay in foster care after hospitalization and improve the parenting behaviors of biological families.

In this specialized foster care model—which is equally applicable to non-abused children with similar medical problems—a registered nurse is the principal caretaker in each home.[1] The Department of Health and Rehabilitative Services (HRS) Foster Care Division is responsible for training and licensing the foster parents and for case management. Medical foster families work closely with biological parents, acting as role models, teachers and advocates in an effort to strengthen families. Close interaction between medical foster families and biological families is necessary to establish trust, improve parenting skills and protect the parent-child bond. Frequent home visitation enables biological parents to practice new child care tasks under the supervision of nurse foster parents.[2]

Medical Foster Care began in 1980 as a pilot project when the Children's Crisis Center (CCC) Child Protection Team identified three children who would have been hospitalized indefinitely due to burns, a tracheotomy, a gastrostomy and malnutrition resulting from abuse and neglect. The CCC recruited three foster homes in which one parent was a registered nurse and both parents were willing to work closely with the biological parents. The child protection team provided intensive psychological and social services. As a result, two of the children returned to their parents in less than 24 months; at that time, the average stay in regular foster care in Florida was 42 months. Their parents were habilitated to the point that social services were no longer needed. Following the resolution of acute medical problems, the third child was placed in regular foster care.

Based on the success of the pilot project, the Medical Foster Care program received a demonstration grant in 1983 from the National Center on Child Abuse and Neglect (NCCAN). Of the seven children served during the first 12 months of the demonstration project, five were returned to their biological families, with Medical Foster Care placements ranging from six weeks to nine months. Children served included those with brittle diabetes, burns, failure-to-thrive syndrome, amputated finger tip secondary to neglect, bronchopulmonary dysplasia, and fractures secondary to abuse and head trauma.

The grant to the Children's Crisis Center covered the program's operational and administrative costs, including the services of a full-time project coordinator, a half-time foster care case manager, a clinical psychologist on a contractual basis

Biological parents and medical foster parents are given time to meet, establish rapport and begin to build a trusting relationship before a child is placed in the program.

and a half-time nurse researcher. Payment of the nurse foster parents was funded through State Children's Medical Services (CMS) patient care funds. Medical foster parents received the basic foster care rate of payment, plus an additional $400 to $1,000 per month for nursing care as determined by a "complexity of care" scale. Patient care dollars, which would have paid for hospitalization, were used to fund the nursing care subsidy.

In one year, placement of seven children in Medical Foster Care saved an estimated $245,116. The actual patient care costs of the seven children was $17,034, compared to projected hospital costs of $262,150.

Currently, funding is provided by a consortium of the Nemours Children's Clinic, which is a private foundation, and the State Department of Health and Rehabilitative Services.

Nurses As Foster Parents

The rationale for using nurses as foster parents is based on their licensure, responsibility and accountability for nursing practice. Moreover, biological parents seem more willing to listen to the advice of a professional nurse than to parents without such credentials, and nurses have clinical assessment skills and are accustomed to patient teaching.

Recruitment

The most successful recruitment strategies for medical foster parents have been through ads in the classified section of the daily newspaper and through word of mouth. Generally, the nurses who answer the ads are at home with school-aged children and want to earn money but are not totally dependent on the income for basic living expenses. A second commonly expressed reason is an interest in maintaining nursing skills.

Legal Issues

Nurses in Medical Foster Care must be currently licensed in the state and have their own professional liability insurance.[3] After seeking legal advice concerning who the nurse foster parents could use for babysitting and occasional respite care for the children, medical foster parents in the demonstration project were required to choose Registered Nurses whose names and qualifications were made known to the Department of HRS. In some instances, other medical foster families would keep a child for a brief period. Access of nurse foster parents to medical records and performance agreements was also legally sanctioned.

Case Management

Research indicates that intensive case management is associated with reduced time in foster care placement [4], and it was possible during the 15-month demonstration project to have an identified foster care case manager with a caseload limited to Medical Foster Care clients. Both an assigned agency caseworker with a small case load and an HRS foster care case manager are needed to work with biological families and medical foster families.

Using the Court System

Children are placed in Medical Foster Care as an alternative to hospitalization only when biological family members are unable to take on the parenting responsibility or are neglectful or abusive. Despite good intentions, some biological parents have difficulty following through with treatment plans. Use

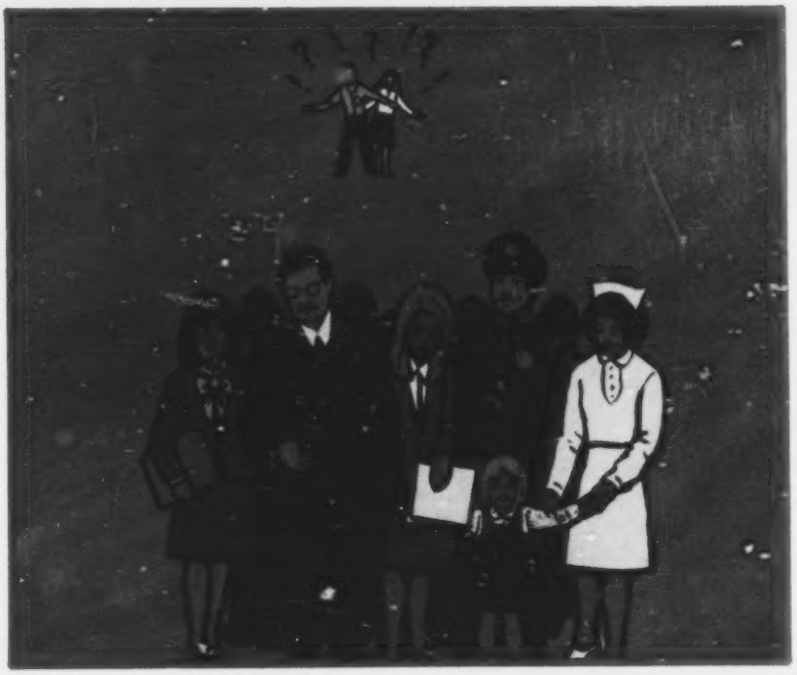
Illustrations courtesy of the Medical Foster Care Program.

The rationale for using nurses as foster parents is based on their licensure, responsibility and accountability for nursing practice.

of external controls, such as the court system, sometimes proves necessary to ensure compliance. In selected cases, especially short-term placements, voluntary placement proved to be effective as well. Failure-to-thrive infants are often appropriate for voluntary placement.

Treatment Plans

To determine eligibility for placement in Medical Foster Care, a Child Care Assessment Tool has been developed to assist in determining the level of nursing care required.[5] Patient care problems, goals and treatment plans are documented in an effort to return children to biological parents or relatives or to place them in regular foster care when their nursing care needs are resolved.



Close interaction and open communication keep biological parents involved with their child's treatment plan; otherwise, they may feel left out.

Matching Families

Prior to placing a child in Medical Foster Care, the biological and foster families meet to establish some rapport and discuss treatment goals, roles and responsibilities. Medical foster families are expected to invite biological families into their homes and to teach them child care skills, specific treatment techniques and general coping behaviors. Both sets of parents need to feel they can work together to accomplish the necessary goals. Medical foster parents are given the choice of taking a specific child into their homes. Some nurses are expert in burn care; others feel comfortable with tracheotomies and apnea monitors. Some families are suited to parenting older children, while others prefer babies. Taking these variables into account tends to enhance the attachment of medical foster families to children.

The Foster Parenting Experience

The medical foster families who participated in the demonstration project went through phases of anticipation followed by turmoil when children were first placed. Children who had been neglected or abused and who had been confined to a hospital environment prior to foster care placement exhibited unpredictable behaviors as they reacted to different settings. Some cried, some withdrew and others wandered aimlessly. Their initial adjustment period lasted from several days to weeks. Once foster families settled into routines, they began to experience the rewards of foster parenting as they helped the children grow well and happy. After the health care problems were resolved or stabilized, the medical foster families were able to focus more on the biological parents' needs and work toward returning the children to their homes.

Guidance and Support

Professionals working with medical foster families need to recognize the importance of the phases families go through during the process. Anticipatory guidance can help both foster and biological families cope with the experience. In the CCC model, biological families are invited into the medical foster family home prior to a child's placement so they can see where their child will live. Once a child is placed, the foster family needs a "settling in" period of three to four days to allow parents to begin to incorporate the child into the family system.

To enhance professional recognition and facilitate entry into hospi-

tals and community agencies, nurse foster parents are given name pins with "R.N." and "Medical Foster Care." During the demonstration project, monthly group meetings of medical foster families and professional staff provided a viable and necessary support system.

Program Operation

A few case examples may help to clarify the function of the Medical Foster Care program.

Norman was born with hydrocephaly and a heart defect. Corrective surgery was accomplished, but his recovery was complicated by the need for a tracheostomy, a surgical opening into the trachea to facilitate breathing. His mother, a single parent, was unable to provide a home environment or to take responsibility for his day-to-day care, and Norman was hospitalized from birth until he was discharged to Medical Foster Care at 18 months of age.

Through the support of a multidisciplinary team, Norman's mother made great strides. Within six months she gained steady employment, purchased a car and put a deposit on an apartment. She acknowledged Norman's existence to her maternal grandmother for the first time, and she visited her son four times a week in the medical foster home and on several occasions stayed overnight. In three more months, she was ready to bring Norman home. She continued to work during the day while Norman attended a medical day care facility.

Bobby, age three, suffered severe second- and third-degree scald burns inflicted by his mother. His maternal grandmother attempted to provide care after Bobby was released from the hospital, but his injuries became infected, requiring re-hospitalization and grafting of the burn site. When first placed in the medical foster home, Bobby would sit "wringing" his hands; within six weeks his burns healed and he was playing happily, no longer fearful of strangers. His grandmother visited him regularly at the foster home and participated in his care. Her parenting skills improved as she relaxed her rigid, unrealistic rules for a 3-year-old and moved toward more appropriate expectations. Within five months Bobby was discharged home to his grandmother.

Allison and her twin sister were born prematurely. At 17 months of age she was admitted to the hospital with a diagnosis of nonorganic failure-to-thrive syndrome. Her 38-year-old mother had a history of depression and alcohol abuse. After five weeks of hospitalization, Allison returned home, and the family received support services, including day care for high risk children, homemaker services and protective supervision. However, Allison soon exhibited signs of withdrawal, apathy, depression and weight loss to the point that her life was in danger if the regression continued. After she was moved to a medical foster home, Allison began to gain weight and develop rapidly. Soon she was walking, talking and socializing appropriately. She and her siblings were later placed with relatives because of her mother's alcoholism and the instability of the home.

Replication of the Model

Much interest has been shown locally, regionally and nationally in replicating the Medical Foster Care program developed by the Children's Crisis Center. The model is easily adapted to fit community needs, and it can be readily assimilated into existing health and human service agencies. Moreover, it has proven to be extremely cost-effective: Medical Foster Care saves a minimum of 300 patient care dollars per day per child when compared to the cost of hospitalization in an acute care facility.

We hope that as others become aware of the tremendous cost savings and the potential for reunification of families in a reasonable period of time, Medical Foster Care will gain recognition as a viable component of the foster care system. With appropriate modifications, it provides an effective and efficient way of reuniting parents and children with chronic or debilitating diseases. ■

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The Deaf Child in Foster Care

by M. Teresa Arcari and Beth Gwinn Berman

Open communication with the deaf child is as important for the social worker as it is for foster parents.

Although considerable emphasis has been placed on the issue of permanency planning for children in foster care, significant barriers must often be overcome in order to attain this goal. This is especially true when children who have special needs—in this instance, deaf children—are placed in homes ill prepared to meet their needs, and when workers responsible for planning for them do not have sufficient information about the disability or available resources. Although reference is made to foster care throughout this article, all points made are equally valid in the identification of appropriate adoptive homes.

Advocates for Hearing Impaired Youth, Inc., which was formed in 1982 for the specific purpose of assessing the needs of the estimated 4,000 to 5,000 children with hearing impairments placed under the care of social service agencies, is committed to providing child placement professionals with some awareness of and sensitivity to these special needs. The effort has grown out of the perception that in most cases, deaf children are inappropriately placed in substitute care. Increased knowledge of the issues specific to hearing impairment will help to ensure progress toward the goal of permanency planning for deaf chil-

dren and avoid needless multiple moves.

A central area of concern involves the identification of foster families with communication skills that match the needs of individual deaf children. Those children with severe to profound hearing loss will most often use manual communication—sign language—in place of, or in addition to, speech. In seeking parents with sign language proficiency, the value of working with the child to attain as much speech as possible should not be overlooked. However, the use of total communication (both signing and speech) in order for deaf children to achieve early exposure to language is also important.[1] Whatever the final decision regarding the most appropriate communication style, it must be based on adequate knowledge about these issues.

Placement Concerns

Typically, social workers have had little, if any, exposure to deafness and have only a limited idea of what the "individual needs" of a deaf child are. Because of family crises, placements frequently occur without much time for planning. The deaf child is often placed with foster families who have boundless good will but no knowledge of the disability and no sign language skills.

In those rare cases where the social worker has some beginning knowledge of sign language, his or her skills most often fall short of the ability to explain to a child the events that are taking place. Frustration and disappointment for family and child usually result. The child faces two alternatives: quiet "adjustment" to a setting that affords very limited communication and often results in a sense of isolation that is extremely damaging, or acting out behavior that precipitates one move after another.

Angie's case illustrates the difficulties that may be encountered by the child, the foster family and the social worker.

Angie, an 11-year-old girl living in a large institution for dependent children, was one of the first children assigned to the social worker—who had had no previous contact with deaf individuals—for placement in a foster home. Prior to that, Angie had been placed in a residential center for severely disturbed children with the diagnosis—later to be found inaccurate—of "selective mutism" thought to result from Angie's experiences with her schizophrenic mother, whose bizarre behavior left her without any clear idea of normal, day-to-day life. (The children in this family often needed to beg meals from the neighbors or look for food in the trash. The mother performed strange religious rituals in the home and was often found wandering naked in the streets.) Based on this history, the original diagnosis was, in fact, a good guess, but wrong. The correct diagnosis of profound hearing loss was finally made when Angie was 10 years old and she was moved to the institution.

Although neither the worker nor the prospective foster parents had any sign language ability, they tried to prepare Angie for placement through drawings, gestures and carefully planned day trips. Despite their efforts, the final placement was quite traumatic. When she saw her suitcase, Angie knew that this was to be a big step and she was terrified. She threw a temper tantrum and attempted to get out of the car while it was moving on the highway.

After arriving at the new foster home, Angie sat on her suitcase for several hours. Through drawings and the kind, patient behavior of the new foster parents—and perhaps because she was too tired to fight anymore—Angie agreed to stay overnight. This began a long, uphill battle toward successful adjustment and growth.

Unlike Angie's foster family, most do not follow through to learn sign language—a process that takes a significant investment of time and energy—even after expressing an initial interest. While they are trying to help the child fit in with the new family, foster parents of a deaf child are simultaneously working cooperatively with special school placements, learning about the care and use of a hearing aid and taking the child for further audiological tests and perhaps additional speech therapy. Only the very committed succeed with so many demands.

In order to be fair to both the deaf child and foster family, foster parents must be identified who already possess basic communication skills and a knowledge of the disability.

Recruitment

Where would a child placement agency begin to recruit foster parents with the necessary knowledge and skills? If the agency has the good fortune to be located near a school for the deaf, this facility may have staff with sign language ability who would be interested in accepting a child into their home. Parents with a deaf child who have developed self-confidence from dealing successfully with their own child's disability may possess the needed communication skills and be willing to extend themselves to other children.

Individuals who grew up with a deaf sibling or whose parents were deaf often have fluent sign language skills and the needed sensitivity. Because these individuals frequently have regular contacts with hearing impaired adults in the deaf community, they can provide their deaf children with successful role models. The well-developed network of deaf clubs and deaf church congregations provides additional major meeting places for those with the skills neces-

A social worker who can use sign language effectively is able to communicate directly with the child and can broach the many ongoing problems needing clarification.

sary to raise deaf children, and these sources should not be overlooked in any serious effort to recruit appropriate foster homes.

This, of course, raises the question of active recruitment of deaf adults as foster parents. Why not tap this ready-made resource? The practical problem that must be confronted is the communication barrier between worker and prospective foster parents—a barrier that is not insurmountable.

A fundamental question that may need to be addressed first is whether agency administrators and workers view deaf indivduals as "handicapped." When deaf adults are seen in this light, they are perceived as those who *receive* services rather than as possible service *providers*. Often, child placement professionals do not see the deaf community as having capable adults who can impart valuable coping skills to deaf youngsters. Agencies do not seem to be aware of a responsibility to hire qualified sign language interpreters to facilitate the process of identification and matching of deaf children with deaf foster parents. These service gaps tend to be pervasive in spite of the provisions of Section 504 of the Rehabilitation Act of 1973 (P.L. 93-112). This Act states that any agency may not deny a handicapped person the opportunity to receive benefits or services that are equal to those offered non-handicapped persons, and may not provide them with benefits or services that are not as effective as the benefits or services provided to others.

Issues During Placement

With the arrival of a deaf child in the foster family, new demands are inevitable. Accommodation always requires a shift in attention and efforts to help the newcomer gain an equal footing with existing family members. Obviously, this does not happen overnight. Considerable adjustment is required for each person in the home. For example, any discussion in the presence of the hearing impaired child, whether directly related to the child or not, should be signed. Allowing conversations to be "overheard" enables the child to become privy to the thousands of incidental exchanges that normally occur in any household. A considerable amount of information about relationships and day-to-day living is learned in this way.

If the family does not already have strong ties in the deaf community, special efforts may be required to find appropriate church congregations and social clubs. Visits with deaf peers from school, who often live some distance away, will need to be arranged. Such requirements must be identified and discussed with prospective foster parents ahead of time. They should also be encouraged to ask themselves two basic questions: Will I become tired of the extra effort? Will I wish these special needs would go away?

Frequently there is the subconscious hope, by both natural and foster parents, that if enough energy is invested, the deaf child will eventually become like a hearing person.

Social workers must be attuned to the many factors that affect success in permanency planning for deaf children.

Helping the child to maximize residual hearing through the use of hearing aids and fostering development of verbal skills through speech therapy are desirable steps to be taken. However, when the disability does not magically disappear, many parents become discouraged. The reality is that the deaf child does not become like them, a part of their hearing world. At this point parents often feel that they have failed and greatly curtail efforts on behalf of their child. Realistic recognition of the child's limitations from the beginning and encouragement of his or her strengths, interests and abilities can guard against their fantasy of "rescuing" the child from deafness.

Natural parents raising a deaf child need to know something about how hearing loss affects the stages of development.[2] Foster parents must consider this information, as well as additional factors related to the more complicated life experiences of children who come into foster care.

It may also be that the child's natural parents—overwhelmed with personal problems and unable to communicate effectively—abandoned any effort at consistent discipline. In addition, the child probably harbors deep anxieties about the meaning of the placement. Without clear and consistently available communication to ease these anxieties and set up behavioral guidelines, the child's activity level may be well beyond what is acceptable.

At the opposite extreme is the youngster who has deep-seated feelings of worthlessness related to the handicap. This child is convinced that the disability, which may have represented additional stress for the family, ultimately resulted in his or her rejection. In the new foster home the child pushes aside needs and worries in an effort to be found acceptable. If the child learns that it is desirable to express feelings and that people are sensitive to concerns, such groundwork will build a foundation for healthy interpersonal relationships.

The young deaf child who "adjusts" to a foster home and to the measure of security it provides in spite of very limited communication initially presents few difficulties for foster parents or the agency. This is not to say that the situation is problem-free for the child. Rather, issues tend to lie dormant, only to appear with the onset of adolescence.

For example, the concern has often been voiced that deaf individuals are slow to develop an appreciation for the feelings of others.[3] This should not be a surprise if the deaf child has not had continual help in sorting out the reactions of others to specific behaviors or in the comparison of feelings. Again, professionals working with deaf teenagers in foster care say that these youngsters seem to have missed out on internalizing the foster family's rules and values. The question to be answered is the same: Can one internalize values without continued exposure to them through family communication?

Yet another problem to be considered is that many children come into placement as the result of physical and sexual abuse. Deaf children are particularly susceptible to both. Physical abuse may have occurred because of the added frustration the disability posed for the family. The incidence of sexual abuse is believed to be high because of the perception that deaf children cannot "tell" about these experiences. Because most deaf children do not receive help in sorting out these events, they are ill prepared to deal with such normal adolescent issues as developing self-esteem and sexual development.

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Adolescent Concerns

Parents and workers who do not have a means of coping with significant issues early in placement face almost certain failure during adolescent years. This point is illustrated by Dana, a teenager who grew up in foster care.

During the early years Dana exhibited few difficulties and, in fact, was exceptionally compliant and not very outgoing, even among deaf peers. She had been sexually abused as a child but no one had helped her to work through these incidents. In an effort to protect her, her foster parents set up strict limits regarding her socialization outside the home, while communication at home remained on a superficial level.

Adolescent conflicts brought extreme rebellion from Dana, sexual acting out and an inability to discuss her feelings or to be helpful in making decisions regarding her future. She was finally admitted to an inpatient psychiatric unit, a placement which helped her to stabilize and then move on with her life. It seems clear that a crisis of this proportion could have been avoided 10 years earlier by more sensitive planning that included help with building on the understanding, self-esteem and communication necessary to cope with adolescent pressure.

While identity is an issue faced by all teenagers, it is further complicated for those in foster care by the need to resolve conflicted feelings related to both birth and foster families. The issue of security vs. independence can also trigger heightened anxieties. Because the deaf adolescent in foster care deals with these issues and with identity as they relate to the disability, problems of wanting acceptance and not wanting to appear different become intensified. Often, there is a time of rejecting either the deaf or the hearing world in an effort to find a "fit" that is comfortable. The deaf adolescent is seeking answers to the questions of Who am I? and Can I negotiate both worlds?

Preparation for independence from the foster home presents a final area of concern. Do the foster parents have a sufficient grasp of career possibilities for their deaf youngster to encourage creativity in setting up employment goals? Or do they—through a lack of knowledge of these possibilities—demonstrate overprotectiveness and the expectation that deaf individuals will always have to depend on others? Deaf teenagers must possess the confidence that comes from knowing that they have been prepared for independence. Without this, the future is bleak, and serious depression can develop.

Worker-Agency Responsibilities

Helping foster parents to cope with so many issues on a daily basis underlines the role of the social worker and agency. The worker must be attuned to many factors that affect success in planning, including the implications of the degree of hearing loss; the pros and cons of various communication methods and educational placements; and the validity of psychological/ I.Q. testing methods. In addition, the worker must be knowledgeable about the use of TDD's, T.V. decoders, interpreters and signaling devices; Social Security benefits and other aspects of federal law as it relates to education and access to other public services; and career planning and vocational rehabilitation services.

Open communication with the deaf child is as important for the social worker as it is for foster parents. A social worker who can use sign language effectively is able to communicate directly with the child and can broach the many ongoing problems needing clarification. When social workers do not have this skill, they need to know how to identify qualified interpreters and how to use them appropriately. Workers demonstrate an understanding of the importance of maintaining confidentiality and impartiality by following these procedures and avoiding the use of family and friends as informal "interpreters."

It is important that agency policy backs these efforts fully. For example, agencies need to spell out clearly how a social worker is to obtain an interpreter for court appearances or for an individual interview with a deaf client. Who pays? Is there a special contract for hiring interpreters? Is the procedure clear and reasonably quick?

Traditionally, social service agencies have not made an effort to hire deaf social workers or workers with any specialized knowledge of deafness. As a result, cases involving deaf children are often randomly distributed among workers, a procedure that precludes the identification of special needs and the development of adequate services. Resources remain scattered. The recruitment of foster parents who already possess an awareness of deafness-related issues and communication skills is not generally recognized as necessary. Moreover, recruitment of deaf foster parents—ready-made role models for deaf children—has rarely been pursued as a solution.

It is imperative that child placement agencies begin to develop increased sensitivity to these issues. Until tangible changes occur, permanency planning for deaf children simply will not exist. ■

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[1] E. Mindel and M. Vernon, "Oralism Only or Total Communication," in *They Grow in Silence*, Silver Spring, Md., NAD Press, 1971.

[2] For a discussion of this issue, see H. Schlesinger and K. Meadows, *Sound and Sign, Childhood Deafness and Mental Health*. Berkeley, University of California Press, 1972.

[3] Ibid.

KID-ABILITY: Takin

by Nayda Rondon

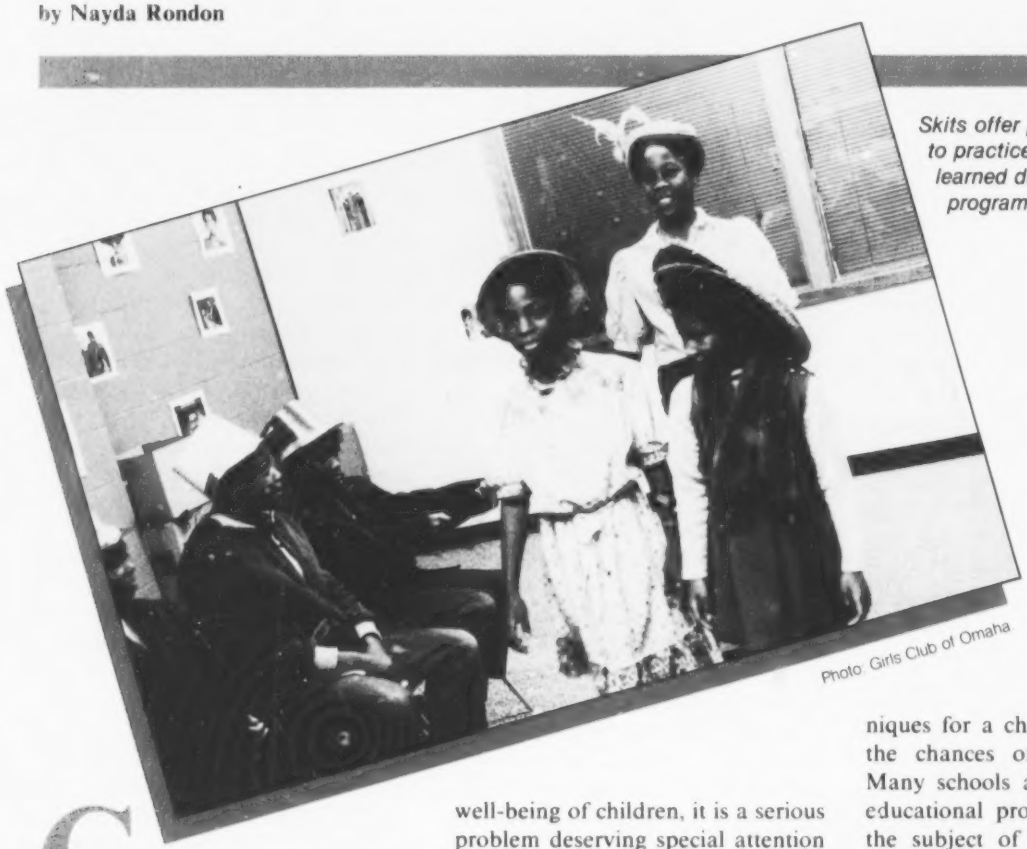

Photo: Girls Club of Omaha

Skits offer participants a chance to practice what they have learned during the KID-ABILITY program.

Child sexual abuse prevention and intervention programs are increasing in numbers and strength across the country as more and more groups recognize the very real, and largely unmet, need for programs of this type.

Girls Clubs of America, a national not-for-profit service and advocacy organization for girls, and its 240 affiliates are among those working on this issue. Currently, 81 percent of Girls Clubs surveyed offer child abuse preventive programs, many of which specifically focus on sexual abuse prevention.

"Although child sexual abuse concerns everyone interested in the well-being of children, it is a serious problem deserving special attention from Girls Clubs because, as data in this field suggest, girls are the primary victims of such molestation," notes Margaret Gates, GCA National Executive Director. "GCA, as an organization devoted to helping girls, must both alert them to the danger and show them how to avoid being victimized."

"To be safe, children need both to understand the threat and know how to respond effectively," adds Phyllis Ross Schless, GCA President. "While parents should assume the major responsibility to speak to their children on such a topic, most never do. Furthermore, even parents who recognize the danger often don't know the best techniques for a child to use to reduce the chances of being victimized. Many schools also shy away from educational programs dealing with the subject of child sexual abuse prevention. It is therefore vital that we do what we can to show children, especially young children, in a non-threatening, age-appropriate manner how to protect themselves from sexual molestation."

One of the pioneers to tackle this issue was the Girls Club of Portsmouth, Virginia, with its "Cat and Mouse" program. This self-protection course for children was started in 1978 and proved so effective that it was soon being replicated by several other clubs, including the Girls Club of Omaha, Nebraska, which adapted and expanded "Cat and Mouse" to create its own child sexual abuse prevention program called KID-ABILITY. Last Sep-

Action Against Child Sexual Abuse

tember, the National Center on Child Abuse and Neglect awarded the Girls Clubs of America and its Nebraska affiliate a $150,017 grant to develop, over a 15-month period, a national training and replication project that will enable professionals from Girls Clubs and other youth-serving agencies to implement their own KID-ABILITY programs.

Its major objectives are to deliver comprehensive training to service providers by recruiting at least 24 local Girls Clubs and 20 other youth-serving agencies nationwide to conduct local KID-ABILITY programs for group facilitators, who in turn teach the children; develop program materials for the use of these and other service providers (see accompanying box); and disseminate information about child sexual abuse prevention strategies to a wide audience of service providers, including all of GCA's 240 club centers.

The KID-ABILITY program aims to increase children's self-esteem and confidence, provide them with guidelines for assessing safe vs. unsafe situations and appropriate vs. inappropriate touch, and help them learn how to obtain help in problem situations.

The program has already had an impressive record of success. Since the Omaha project began in 1982, more than 10,000 school-age Nebraska children have learned to protect themselves from physical and sexual abuse and to practice assertiveness techniques and responses. And the national training and replication project is well underway. According to Catherine H. Smith, KID-ABILITY Project Manager, 28 Girls Clubs professionals from various parts of the country as well as 20 representatives from outside organizations, such as Big Brothers/Big Sisters, YWCA, the Salvation Army, Planned Parenthood and several church groups, have received instruction in how to adapt the basic Nebraska workshop model to their own communities' special needs and populations. Requests for workshop presentations have been received from 44 states, Canada and Australia.

"Based on the comments we've gotten back from the evaluation questionnaires," Smith said, "it looks as if we're on the right track. We're also taking some of the suggestions offered by the participants to refine the program and the training process."

As presently designed, the 8-hour KID-ABILITY program model helps girls and boys, ages six through 12, to recognize and effectively deal with potentially dangerous situations by taking a positive, non-frightening approach through the use of games, role playing, large and small group discussions and carefully selected films. Special emphasis is put on having participants practice skills, build their self-confidence and learn how to identify trustworthy adults.

"There is more to this program than 'don't talk to strangers,'" stresses National KID-ABILITY Director Mary Kay Hockabout. "It's not a sex education or a karate class. We teach children that they are not powerless against an adult. The children in the program learn to protect themselves by using what they have—a strong posture and assertiveness."

"KID-ABILITY teaches self-protection rather than self-defense," points out Jane Quinn, GCA Director of Program Services. "We try to emphasize the positive aspects rather than the negative. 'Scary' terms or tactics are avoided as teaching methods. Instead, we try to get the points across in non-threatening, easy-to-understand terms that children can relate to. For example, the concept of sexual abuse is simplified by relating it to other kinds of problems more easily understood by children, such as equating the behavior of an uncle who tries to coerce a kiss from a reluctant niece to that of a bully trying to take a favorite toy away from a younger child."

The self-protection program teaches children how to identify and practice reponses to such situations as asking for help, discouraging a touch or answering the door or telephone; become familiar with the people and agencies in their communities—a teacher, policeman or child abuse hotline—that can offer assistance; develop safe personal decision-making skills, such as being able to confidently tell certain adults that their touches are unwanted and uncomfortable; and distinguish between a gift and a bribe, a secret and a surprise, and different kinds of touches.

KID-ABILITY is usually conducted over a 3-day period in elementary school classrooms by volunteer facilitators, who arrange the presentations with the school system. The volunteer facilitators, most of whom are parents but who also range from senior citizens to single adults, receive special instruction to learn the best methods to reinforce the program lessons. Working in small team groups with three to five children, the facilitators lead activities and discussions—and encourage the children to feel comfortable with each other.

Hockabout—herself a mother, who first got involved in the national KID-ABILITY program after she and partner Barbara Kaiman, a public health nurse, worked as coordinators who took the program to various local communities—credits the facilitators' efforts with a large part of the program's success on the local community level. "Not just anyone can be a facilitator, and the success or failure of the program depends on the facilitators," she emphasizes.

After conducting a KID-ABILITY workshop in the Underwood, Nebraska, elementary schools, facilitator Kathy Whitson commented, "I felt that the program did a good job positively looking at potential concerns without frightening the children. They were encouraged to recognize that they had strengths, and the program worked hard on helping the children build their self-confidence."

"The kids in my group seemed to have learned much from it," added Deb Raanes, another volunteer. "We did a lot of role-playing. The older kids really enjoyed acting out how they would react in different situations."

Before presenting the program in the schools, the facilitators hold an orientation session for parents of children who will be participating in

KID-ABILITY Program Materials

The following materials have been developed for use in the Girls Clubs KID-ABILITY child sexual abuse prevention program:

- **Children's Journal** ($3.00). Designed to contain a child's personal record of activities, experiences and feelings during the workshop, this 50-page journal includes sections to be completed during the workshop, at home following the workshop, and months later as skills are sharpened. A section of local resources to contact for help are included for the child's easy reference, as are perforated pretest and post-test pages for use during the program.

- **Volunteer Team Coach Guide** ($3.00). Also 50 pages, this booklet contains instructions for guiding children through the *Children's Journal*, a program agenda, the expectations and role of the facilitator, instructions on how to conduct the role-plays and how to listen responsively. It also includes sections on managing behavior problems; responding to reports or suspicions of child sexual abuse; and programming for children with special needs, including those who have been sexually abused. In addition, the guide contains two tear-out evaluations as well as a certificate of appreciation for the volunteer facilitator.

- **Parent's Guide** ($3.00). This guide, which is still in the production stage, will contain advice and activities to help parents protect their children by reinforcing and building self-esteem, confidence and assertiveness and by fostering family communication. The guide's general focus will be to stress parents' need to be approachable and to help their children protect themselves through the acquisition of safety information and skills. It will also list additional resources and self-help groups for those who have undergone child sexual abuse.

- **Trainee's Manual** ($35.00). This 200-page manual consists of three parts: **Part One,** "Workshop Implementation," contains all program content and instructions for presenting children's workshops. It includes the rationale behind activities and methods of presentation, and also orients trainees to the use of other program materials. **Part Two,** "Program Promotion and Management," contains the materials for parent presentations, speakers' bureau, facilitator training and board orientation, and also includes policies and record-keeping documents. The **Appendix** includes an annotated bibliography and list of selected background readings in child sexual abuse.

All of the materials, except for the *Trainee's Manual,* are available from: Child Sexual Abuse Prevention Unit, Girls Club of Omaha, 3710 Lake Street, Omaha, NE 68111.

Children exhibit their team banner, which is made to build group unity and give children an opportunity to identify and draw pictures of their personal strengths.

Photo: Journal-Star Printing Co

the KID-ABILITY program. The session covers background information on child sexual abuse, abuser tendencies and how to recognize signs of abuse, and it affords parents an opportunity to ask questions and clarify any concerns about the program.

Parents are usually highly enthusiastic. Carol Dean, a school board member and mother of three children, noted that the program was not only tastefully presented, but that "the feeling of self-worth and capability transmitted to the kids became a tangible value for all to see."

Jeanne Lincoln, another mother who is also a foster parent, observed that through KID-ABILITY "a child learns that she or he is a little person, but also a very important, strong individual who is capable of making very important decisions. The program teaches children to be aware at all times of what is going on around them, to be alert and react to problems that might arise, not only with a stranger but with a loved one."

Although the emphasis is on prevention, the program also addresses and tries to help children who have been or are being abused. Sometimes during these sessions, children actually confess to having been victimized.

Eleven-year-old Jenny, for example, became visibly uncomfortable during a KID-ABILITY workshop when the instructor began discussing "problem touching." Later, as the group viewed a film on the same subject, she burst into tears. Hurriedly excusing herself, Jenny ran into the bathroom and refused to talk about what was wrong. It was not until the last workshop session, which emphasized the importance of whom to ask for help and how to do so assertively, that Jenny felt she would confide in someone. "There is sexual abuse going on in my family," she privately admitted to the facilitator, and went on to recount how she had been sexually abused by her two brothers for the past four years.

It's too late to prevent the occurrence of child sexual abuse for innocent victims like Jenny, but, thanks to programs such as KID-ABILITY, it's not too late for others. More and more children like 10-year-old Carrie, who participated in the Omaha program, will be able to say, "I learned a lot, but I hope I'll never have to use any of it," and have their wish fulfilled. ■

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Missing Children

A Close Look at the Issue

Missin

by Howard Davidson

Few youth-related issues have so emotionally gripped the American public, and so galvanized legislators, as has the plight of missing children, nor have victims ever before played such a major role in policy development. Until three or four years ago, few of us working to improve the child protection system had ever given much thought to these matters.

Among the parents who organized themselves to address child kidnapping problems, those who had a child disappear as a consequence of a parental abduction were the first to mobilize, and their outcries were heard. In 1980 Congress passed a law to help secure the FBI's involvement in investigating interstate felony parental kidnapping cases (the Parental Kidnapping Prevention Act); all 50 states have passed a uniform law governing the handling of interstate child custody disputes (the Uniform Child Custody Jurisdiction Act); and virtually every jurisdiction has specifically made interstate parental abduction a crime, thus encouraging the use of FBI investigations to help locate the abductor, as well as state extradition proceedings to secure the apprehension and return of parental kidnappers who are found in another state.

In late 1981 the country began to hear from other victims: Those parents whose children had been abducted by unknown individuals. Such children are often erroneously referred to as "stranger abduction" victims. In truth, many of these abductors turn out to be people who were previously known to the child and often to the parent as well. Many of these children are sexually molested during the period of their abduction, and some are murdered. Teenaged victims may initially accompany their "abductors" voluntarily, only later to be forced into prostitution and threatened with physical harm if they leave. Some very young children are kidnapped by disturbed people looking for an

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infant to care for, while others may be sold in "baby rings." A few young children initially reported as missing actually turn out to have been the victims of foul play at the hands of their parents.

Parents whose children had disappeared under unknown circumstances pressured Congress to enact the 1982 Missing Children Act. This law requires the FBI to record missing children reported to them in their National Crime Information Center (NCIC) computer as an aid to all federal, state and local law enforcement agencies. The impact of that law can be measured by some simple statistics: In 1985 the NCIC received reports of over 332,000 cases of missing children, and its records have shown the existence of over 46,000 children currently listed as "still missing" at any given point in time. Most of these are runaways and victims of parental kidnapping, rather than children believed to have been abducted by "strangers." Parents of missing children and their advocates have also successfully lobbied for the creation of state-level missing children law enforcement information and investigation clearinghouses. Today, more than 30 states have established such central registry/technical assistance programs.

The last (and largest) category of missing children includes those young people whose absence from home is generally voluntary. Again, the terms "runaway" or "voluntary missing" are often misnomers. Many of these children have been pushed out of their homes by angry or neglectful parents, or forced to leave because of severe physical or sexual abuse. While some of these children find stable, healthy living arrangements with caring adults, others become truly "homeless" and drift from shelter to street. Greater congressional attention to the plight of these kids has resulted in increased funding for local runaway shelters under the federal Runaway and Homeless Youth Act and a series of demonstration grants from the Family and Youth Services Bureau, ACYF, dealing with the relationship between missing children and runaway youth programs.

The Lack of Good Statistics

No one knows the exact number of "missing" children. Most parents who call the police on such cases are reporting a lost child, one who probably will return home or be found safely within a few hours or even minutes. Yet, at the time their child has disappeared, parents have every right to receive prompt., sensitive law enforcement assistance, as well as to have the police records accurately reflect that their child is missing. Any parent who even momentarily has had a lost child, or not known of their child's whereabouts, would probably resent the implications of those who suggest that we are taking the issue too seriously.

A large percentage of missing children is recorded by police as probable runaways. In October 1983 the Inspector General of the Department of Health and Human Services estimated that there were as many as one million, and possibly in excess of two million, runaways annually. Thanks to an active network of runaway and youth service programs, the existence of runaway hotlines and the increased activity of police in finding these children, this is the category where successes are the greatest in locating missing children.

Estimates of non-custodial parental child abduction cases vary from 25,000 up to 750,000 per year.

The wide range is caused by difficulties in defining a "parental kidnapping." For example, jurisdictions vary on whether such an act can legally occur if the victimized parent does not have a sole custody order at the time of the abduction, or whether a crime is committed if the child is not taken across a state line. Those of us who are involved in family law developments do know that reports of interference with a parent's custody or visitation rights have increased dramatically over the past decade, and domestic relations lawyers as well as district attorneys are constantly besieged by parents seeking help in recovering a child who has been taken away by (or not returned after a visit with) the other parent.

The last category, abduction by non-family members, has caused the greatest dispute on the use of statistics. Originally, annual estimates by well-intentioned victim advocates of what are improperly called "stranger abductions" ranged as high as 20,000 to 50,000. More modest estimates have placed the number at 4,000 to 7,000. Recently, the FBI indicated that it was presently aware of less than a hundred such children. In truth, the actual number is certainly in the thousands. The FBI's stated figure included only those cases for which it had legal investigative authority. FBI involvement in missing children cases is subject to very restrictive criteria; all but a few child abduction cases remain the sole responsibility of state and local police agencies.

Another problem that causes official police statistics on abducted children to be undercounted is that many children who are abducted in their communities never get officially listed as a victim of the crime of "abduction" or "kidnapping." Often, these children become victims of other crimes, such as sexual assault, and only get designated as such. Others are improperly listed as runaways and never have their designations corrected.

Compounding the statistical dilemma is the fact that there has never been a properly designed national study of the collected reports or actual incidence of these various categories of missing children. Recognizing how critical this is, the 1984 federal Missing Children's Assistance Act (MCAA) called for a study to "determine for a given year the actual number of children reported missing . . . who are victims of abduction by strangers . . . who are victims of parental kidnappings . . . and who are recovered each year." To date, no incidence study has been initiated by the Act's administrator, the Office of Juvenile Justice and Delinquency Prevention (OJJDP), Department of Justice. Unlike the incidence of child abuse and neglect, where the National

Missing Children: A Chronology

Dec. 1974—Joanna Pierce, age 6, daughter of missing children advocate Gloria Yerkovich, disappears after a weekend visit with her father and becomes a victim of parental kidnapping.

May 1979—Etan Patz, age 6, disappears in New York City.

Aug. 1980—Child Find, based in New Paltz, N.Y., is founded by Gloria Yerkovich as a national group dedicated to locating missing children.

Dec. 1980—The federal Parental Kidnapping Prevention Act (P.L. 96-611; 28 U.S.C. § 1738A) is signed into law.

July 1981—Adam Walsh, age 6, disappears from a shopping center in Florida and is later found murdered.

Nov. 1981—A National Symposium on Child Tragedies is held in Louisville, Kentucky (first major conference on this subject); this results in the formation of a Child Tragedies Coalition, which includes many of the emerging leaders in the missing children area. John Walsh, father of Adam, begins his efforts as a spokesperson for reform on this issue.

May 1982—To mark the anniversary of the disappearance of Etan Patz (who is still missing), the U.S. Senate declares May 25 as National Missing Children's Day; the ABA and 10 other national organizations call on Congress to pass a Missing Children Act proposed by Senator Paula Hawkins; conferences and newspaper editorials begin to address themselves to the issue.

Oct. 1982—The federal Missing Children Act (P.L. 97-292; 28 U.S.C. § 534(a)) is signed into law.

Center on Child Abuse and Neglect has funded a related national study as well as annual national reports on aggregate state reporting data, we simply have had no choice but to make educated guesses as to the numbers of missing and abducted children in this country.

National Center for Missing and Exploited Children

Started in 1984 with funding from OJJDP, the National Center for Missing and Exploited Children functions as the national resource center and clearinghouse, and operates the 24-hour toll-free telephone line mandated by the MCAA. The center—which employs about 50 people—also provides technical assistance to law enforcement agencies, government bodies, and other programs on the location and recovery of missing children as well as a range of information and materials related to the safety and protection of children. During 1985 it received and processed almost 100,000 information requests, over 8,000 reports of possible missing child cases (most in the category of parental kidnapping and "voluntary missing"), and almost 17,000 reports (potential leads) from citizens who thought they might have seen a missing child. In more than 3,000 instances, these calls were said to result in the Center's being of some assistance in the return home of a child!

In 1985 center staff personally worked on over 6,000 missing child cases, provided training to some 10,000 law enforcement and criminal/juvenile justice personnel from 32 states, and gave assistance to legislators and citizen groups in over 47 states working on child protection legislation. The center's vast publication activity in 1985 involved the writing, printing and dissemination of a wide range of materials related to the safety and protection of children.[1]

The Continuing Controversy: Too Much Media Exposure?

Today, thanks to groups like Child Find,[2] the National Center and the National Child Safety Council, photos of missing kids appear on TV and in newspapers and magazines, in supermarkets, airports, hotels and restaurants, on envelopes, shopping bags, milk cartons and cereal boxes. The media and many private businesses are anxious to receive and use such pictures. They see this as an inexpensive public service, one that

Oct. 1983—The movie *Adam* is shown for the first of three times on NBC-TV and is seen by an estimated 55 million people (following the film, pictures of 55 missing children are shown); the federal ACTION agency convenes a Missing Children's Project Working Group to assist in their support of a series of volunteer-based child safety day projects throughout the country.

Dec. 1983—The U.S. Office of Juvenile Justice and Delinquency Prevention (OJJDP) convenes an invitational conference in Huntsville, Tex. on missing and exploited children with representatives of over 25 private volunteer-based organizations.

Apr. 1984—OJJDP announces its award of funding to establish a National Center for Missing and Exploited Children.

June 1984—President Reagan opens the National Center with a White House ceremony.

Oct. 1984—The federal Missing Children's Assistance Act (Title IV of the amended Juvenile Justice and Delinquency Prevention Act, 42 U.S.C. § 5601) is signed into law; $4 million is appropriated by Congress for each of the Act's first two years.

March 1985—A National Advisory Board on Missing Children, appointed by the U.S. Attorney General, holds its first meeting.

July 1985—OJJDP publishes final FY 1985 program priorities under the Missing Children's Assistance Act (July 25, 1985 *Federal Register,* page 30310).

March 1986—A National Conference on Missing and Exploited Children is held in Chicago. The Attorney General's Advisory Board on Missing Children issues its first report making a series of legislative and policy recommendations.

can result in a child being reunited with a parent. In one 3-month period, the National Center responded to nearly 2,000 inquiries for missing child information from print and broadcast media reporters. Each week, the center supplies 315 major national organizations with new missing child photos. On the average, the center receives 20 calls daily and 25 written requests weekly for information on the distribution of missing child photos.

Is all this attention to the problem psychologically harmful to the children who view the pictures or hear about the many personal tragedies? Are we frightening kids needlessly? Surprisingly, given all the recent clamor, there have been no studies on this. The National Center has concentrated on using the most tasteful and non-alarmist media approaches, and it has strictly followed formal protocols for the selection and use of photographs. Executive Director Jay Howell has stated: "Just as we teach children fire safety and traffic safety without detailing any frightening consequences, adults need to use better judgment in providing nonthreatening, straightforward rules that will equip the children with the tools needed to protect themselves against exploitive situations."

The fact is that people *do* see and respond to photos, and children *are* recovered because of it. For example, on November 13, 1985, a 2-month-old child was kidnapped in Texas by a person who answered an ad for a babysitter. Through the National Center, the baby's picture was immediately dispatched to the media. A few hours after the child's photo appeared on a national TV show, a woman called the center's hotline and reported seeing the child. The center in turn notified the FBI, which found the child in Florida and reunited her with her mother. The center's files are replete with hundreds of other cases where center involvement, as part of a public law enforcement/private voluntary organization team, helped return a child to his or her rightful home.

Today, there is a great deal of rancor on this important issue. Some people have accused advocates for missing children and their parents of "exaggerating the numbers" and "fearmongering." Others are jealous that the National Center, a relatively new organization, has received more than three million dollars in federal funds over the last few years to perform its tasks. Still others believe that this issue is diverting attention away from more pressing child welfare concerns, with the result that child abuse and runaway programs are not receiving all the attention and financial support they need, even though the center's work is bringing more attention to the problems faced by children served by those programs.

Finally, there are a few cynics with an "ax to grind" who contend that the issue's significance has been exaggerated for self-serving reasons. These people either ignore, are unaware of or unfairly undervalue the long-term commitment of those few parents and professionals who have been in the forefront of making us all aware of, and improving the government's response to, this serious problem. Fortunately, the children of these critics have never been "missing," and it is unlikely that they have ever worked with parents who have suffered through the nightmare of having a child disappear from home. Those parents will attest to how media and law enforcement responsiveness to the plight of their children has dramatically improved since the advocates of this issue began to raise our collective consciousness about this very real national concern. ■

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[1] For a description of the informational materials produced by the National Center for Missing and Exploited Children, see "Child Abuse and Exploitation," FYI, CHILDREN TODAY, Mar.-Apr. 1986.

[2] See "Finding the Missing Children" by Bob Reall, CHILDREN TODAY, Jan.-Feb. 1984.

Project MAIN:
Classwork in the Community Benefits Senior Citizens

by Gerald F. Blake

Collaboration for school improvement and reform is one of the more refreshing responses to recent criticisms of education. Rather than taking a defensive position about the school's mission, the call for increased collaboration among educators, parents and community groups has the potential of revitalizing the classroom by creating opportunities for students and teachers to apply their knowledge in community settings. The continuing erosion of voter support for school budget levies and the high rates of school truancy and dropout dramatize the need for schools—particularly high schools—to reach beyond their immediate environments. Educators will have to take more definitive steps to establish beachheads in the community that will stimulate increased support for schools.

One form that such efforts could take is for educators and students to play a more active role in community problem solving. Uniquely designed projects that merge academic classwork with occupationally related part-time employment demonstrate that the school can play an important role in community improvement.

This article examines the collaborative effort among an urban

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Students learned to shop economically to meet the nutritional needs of the elderly participants.

university, a local high school and a senior service agency to establish human service career learning paths and community service employment. The 12-month demonstration project—called Mobile Assistants in Nutrition (Project MAIN)—employed a team of students, ages 14 to 19, to research, plan and operate a grocery delivery and escort service for elderly and disabled residents living in a targeted neighborhood.

The youths worked after school (eight hours per week) and during the summer (20 hours per week), and were paid the minimum wage of $3.50 per hour. Funding for the project was provided through grants from private foundations.

The designers of the project, the Youth Employment Planning Team (YEPT) at Portland State University, Portland, Oregon, initiated the collaboration to accomplish four goals:

- to create a participation-based youth employment project that would smooth the transition from school to work by enabling youths to explore a variety of medical and human service careers and gain hands-on experience in planning and operating a needed community service.
- to establish new organizational linkages among the university, local high schools, youth agencies and senior service agencies as a means of narrowing the gap between schools and the community.
- to demonstrate the feasibility of blending classroom curriculum with part-time employment as a way to reinforce learning through direct application of classwork in the community.
- to broaden the variety of primary care services provided to the elderly and disabled as a means of maintaining their independence and self-sufficiency.

The project was comprised of three interrelated elements: project oriented learning and youth participation, inter-age contact and cooperation among institutions and agencies.

Learning and Participation

Project MAIN was designed so that students could actively participate in the planning and operation of the service. This required that educational support for the youth blend academic curriculum and job training that directly related to the work of the project—for example, gerontology, to break down stereotypes held about the elderly; nutrition, in order for the youth to understand dietary needs; and consumer awareness, to be able to shop economically. The program recruited 10 students from the cooperating high school and obtained academic and work experience credit for their participation. Educational support was provided by project staff members (graduate students from the university), with assistance from the collaborating agencies and a group of volunteers drawn from the professions that related to the project (health, speech and communication, urban planning, gerontology, nutrition, social work, economics, sociology and environmental science).

The MAIN team studied shopping problems encountered by the elderly and disabled and generated solutions to those problems. The youths learned why grocery shopping was important to the people they served and how they could most effectively organize and deliver

Ongoing relationships between young and old were established.

the service. The education curriculum included gerontology, interpersonal communications, nutrition, disability awareness and grocery economics. Study of these subjects was an ongoing requirement of the job.

The students heard lectures, completed individual reading assignments, participated in small group discussions, visited senior service agencies, and received training in the use of wheelchairs and other mobility devices.

The opportunity to apply newly gained information helped to integrate theoretical knowledge with practical experience, thus making the youths competent and self-confident in the jobs they performed, as well as enthusiastic about learning more.

Inter-age Contact

The second element of the project sought to establish ongoing relationships between the youths and the elderly through frequent contact between participants and shoppers. Regular and predictable interaction between young and old was seen as a vital means of breaking down social stereotypes. Close personal contact alleviated mutual fear and alienation and enhanced the natural affinity between older and younger generations.

Promoting Cooperation

For MAIN to be effective, it was necessary for the various agencies to collaborate in all phases of the project. The students also had to establish themselves as trustworthy and dependable in the eyes of the elderly and the disabled community. The cooperating agencies jointly planned the training curriculum so that the youths would be sufficiently prepared to offer the shopping and escort service, and to ensure that the curriculum met standards for the awarding of school credit.

In order to establish trust and visibility, the project had to become involved in the extensive and longstanding network of senior service agencies in the neighborhood. Gaining the acceptance of this network proved to be difficult because of the members' unfamiliarity with the youths and the negative stereotypes they held regarding the ability and maturity of young people in general.

Involving the agencies in the planning process allowed concerns to be aired and accommodated in the project's design. In addition, having the collaborating agencies participate directly in the students' training and work fostered a shared ownership of the project that strengthened the commitment to make MAIN succeed.

Referrals for the shopping and escort service came from two sources: direct contact with seniors and disabled persons (through speaking appearances at senior housing facilities, door-to-door leaflets and similar efforts) and direct referral from the agencies.

Results

During the 12-month demonstration project, the youths served 238 elderly and disabled persons and logged 1,560 shopping and escort trips to grocery stores. The average shopping trip resulted in the purchase of approximately $18.50 worth of groceries.

The effects of MAIN on the students were judged to be very positive. The students' responses to open-ended questionnaires revealed that they had gained valuable work experience, explored a variety of human service careers, and learned a considerable amount about nutrition, disabilities and aging. In addition, the relationships that were established between the youths and the elderly proved to be much stronger and more enduring than was anticipated. Several students continued to visit and shop for their elderly clients even after the project ended. The participatory structure of the project resulted in instilling a significant amount of pride and ownership in MAIN among students.

Academic and individual benefits of the project are best expressed by the youths themselves. A 15-year-old noted:

"I felt that I fit better here than anywhere else I've been. Usually I am just there, but in MAIN I have a say, I can voice my opinions and give suggestions and they are acknowledged. I also feel good about my role in the community. My job is helpful to both the elderly and the handicapped and myself. I'm doing something constructive while I'm earning money.

"I found that a lot of the people I shop for are really interesting. I like to hear how things were before my time, and I like stories about foreign countries. Some of my clients can talk forever if I let them, but that is expected because so many are lonely. Besides, I feel that I'm helping them out by listening to them because they need to associate with other people."

Another student assessed her experiences with MAIN:

"The training that I received in this program helped me immensely in my own nutrition. I learned a lot about the food chain and eating simple foods. I also got a lot of information on chemical additives

Project MAIN participants all had an active role in improving services in their community.

in food and what they do to you. I passed all of this information on to my mother, who has used it to get the whole family to eat better. To me, that's the most impressive thing that has happened.

"The reason that I enjoy this job so much is that I'm helping people. By providing a means for senior and handicapped citizens to get their groceries, I'm helping them to stay out of the clutches of nursing homes. This makes me feel very important because I am providing a valuable service. If, for instance, I was working as a grocery delivery person out of a grocery store, I wouldn't feel half as good about my job or myself. In this job, however, not only do I deliver groceries, but I also provide companionship and information on nutrition. It's a lot more fulfilling."

The elderly and disabled who were served by the project expressed support and appreciation for MAIN. For several, the MAIN project was the difference between living independently or being moved to an institutional setting. One senior commented:

"It is over a year now that I have been in the MAIN program. Without these very capable young people to do my weekly grocery shopping, I would simply be in a nursing home. My young shopper is well versed in shopping and nutritional needs. We go over the grocery list together. She makes good selections with an eye toward price. Generally, I let her use her judgment on quality and price in fruits and vegetables. But the service rendered to me gives so much more than the needed groceries. It gives me a look at young people who really care. I like what I see!"

The project enabled the senior service agency to expand services to elderly clients. Shopping services that had been provided on a periodic basis by volunteers and staff were supplemented by MAIN's regular, dependable service. The agencies gained an additional benefit from the MAIN project in that the youths became a second set of eyes and ears for caseworkers—enabling them to become aware of problems that an elderly person might be encountering, such as a negative reaction to medication or summer heat. The students' ability to recognize these situations and communicate them to the caseworkers was a direct result of the training and education they received on the project.

Conclusion

The Mobile Assistants in Nutrition project demonstrates that universities, high schools and social service agencies can collaborate to produce solutions to community problems that are academically relevant, enhance the transition from school to work and improve the quality of communities. In this instance, there was a clear community need for food shopping for the elderly and disabled that provided the focus for the collaboration and afforded educators and students the opportunity to respond positively. ■

Book Reviews

Care and Commitment: Foster Parent Adoption Decisions

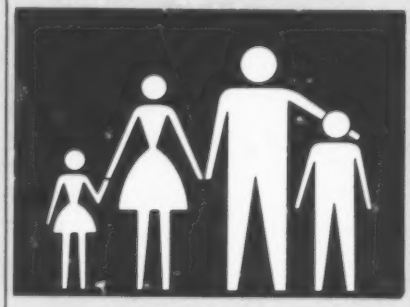
William Meezan and Joan F. Shireman (Albany, State University of New York Press, 247 pp., $39.50 cloth, $12.95 paper)

Reviewed by Elaine J. Schwartz

Care and Commitment, the report of a research study, speaks not only to the researcher and academician but also to the practitioner in foster care and adoption and to the agency administrator. This well-written and interesting book poses the question of why some long-term foster parents choose to adopt the children in their care who become free for adoption while others do not. Specifically, the project addressed five questions about foster families which the agency considered appropriate for adoption:

- Are foster parents who choose to adopt their foster children different from those who choose not to adopt? Are foster parents who ask for removal of an adopted foster child different from either, or both, of the above groups?
- Do children who are adopted by their foster parents have different characteristics than children whose foster parents choose not to adopt, or for whom the adoption is not successful?
- Do children who are adopted by their foster parents have different types of relationships with them than children who are not adopted by their foster parents? Are there similar patterns in relationships when adoptions fail?
- Do foster families who choose to adopt have different perceptions of and experiences with the agency and its policies than those who decide not to adopt? Are these perceptions and experiences different from those who decide to adopt and then have the adoption fail?
- Do workers' perceptions of critical factors in the fostering and adoption experience coincide with those of the foster parents?

The book thoroughly examines and reports on these questions—and some of the answers are not what we might expect. The findings and the implications for practice provide the field with a great deal to ponder.



As the authors state in their conclusions: "Who would have predicted that the actual number of previous placements the child experienced would be a less important discriminator than the reasons these previous placements terminated; that the meeting of initial parental preferences would not be an important discriminator; that early attachment to the family would be less important than the experience between the family and the child over time; or that knowing the biological family would be associated with the foster family's decision to adopt?"

In addition, the study points out the crucial role played by the social worker in adoptive planning and clearly outlines ways in which the worker can be most effective in planning permanency for children. Furthermore, the study indicates that it is best to have a single worker perform these functions, one who knows the child, the biological parents and the foster family and who knows the resources of his or her own agency, as well as other agencies. This is a very large job for one worker, and it may not be possible for a variety of reasons, but the case manager concept may work to provide the coordination needed.

In one area, which discusses children's special needs, reference is made to long-term foster care as a permanent plan for a child. The study suggests that "for some children, who have spent many years in the same home, it is probably the best available option if the foster parents will not, for whatever reason, consent to adoption." This is an area that needs expert judgement to determine at what point long-term foster care could be considered as a viable option for a specific child and committed foster family. Perhaps further study is indicated before the field accepts long-term foster care as a plan for permanency.

The findings of this study provide us, for the first time, with solid information on foster family adoption. It points out once more the great need for research in child welfare. I recommend this book to all those interested in improving adoption services and to researchers to consider further study in this basic child welfare area.

Elaine J. Schwartz is the Adoption Specialist, Children's Bureau, ACYF.

Emerging Issues in Child Psychiatry and the Law

Edited by Diane H. Schetky and Elissa P. Benedek (New York, Brunner/Mazel, 378 pp., $37.50)

Reviewed by Milton F. Shore

Despite historical roots in the juvenile courts, child psychiatry over many decades has veered further and further away from the field of law. A number of mental health professionals, in fact, have felt that there is an inherent conflict between the legal system, which is adversarial, and the mental health system, which is treatment-oriented, with the two unable to work together harmoniously. (This division is exemplified by a psychiatrist's comment regarding deinstitutionalization: "People are dying with their rights on.")

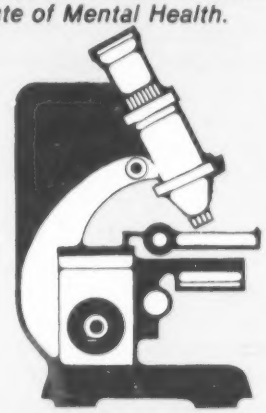
However, attempts to avoid rather than understand the relevance of the law to mental health have led, especially in regard to children, to confusion and sometimes unfortunate results from a child development standpoint. Years ago, for example, it was felt that the best interests of the child were served by automatically giving the mother custody in all divorce proceedings, irrespective of her capacity to take care of the child. Recently, there has been renewed interest in the child psychiatry-law interface, partially resulting from concerns about child abuse and the effects of divorce. A number of mental health professionals have sought legal training, and schools have developed joint programs in mental health and law. Above all, the child advocacy movement, which has recognized its philosophical roots in law, has encouraged a mutual exchange of ideas from both professions.

In 1980, the editors of this book presented one of the first contemporary collections of essays on *Child Psychiatry and the Law*. While this second volume, following after five years, covers many of the same general issues as the first, it also brings up new important areas. Structured similarly to the previous volume, the book covers ethics (in research and treatment), child custody (joint custody, adoption and divorce), the juvenile offender (alternatives to institutions and waivers to adult court) and school issues (special education laws). In addition, it has selections on children's competency to make decisions about treatment, father custody, gay fathers and lesbian mothers, cults, organ transplants, pornography, grandparents and the law, and surrogate mothering.

The book's greatest contribution is the identification of the expanding fields of law and mental health. Unfortunately, the large number and broad range of issues covered in this relatively short book do not permit more than a brief, and sometimes sketchy, introduction to the complexities of a particular issue. The chapters, most of which are very well written by authors of many disciplines, cover the basics (although some areas mentioned in the previous volume are not brought up to date—for instance, the right to treatment).

This volume clearly conveys the excitement of integrating the legal and mental health dimensions in working constructively for the benefit of children, youth and families. Indeed, in order to keep up with the rapid changes in the field, it would probably be useful to have such books at regular intervals.

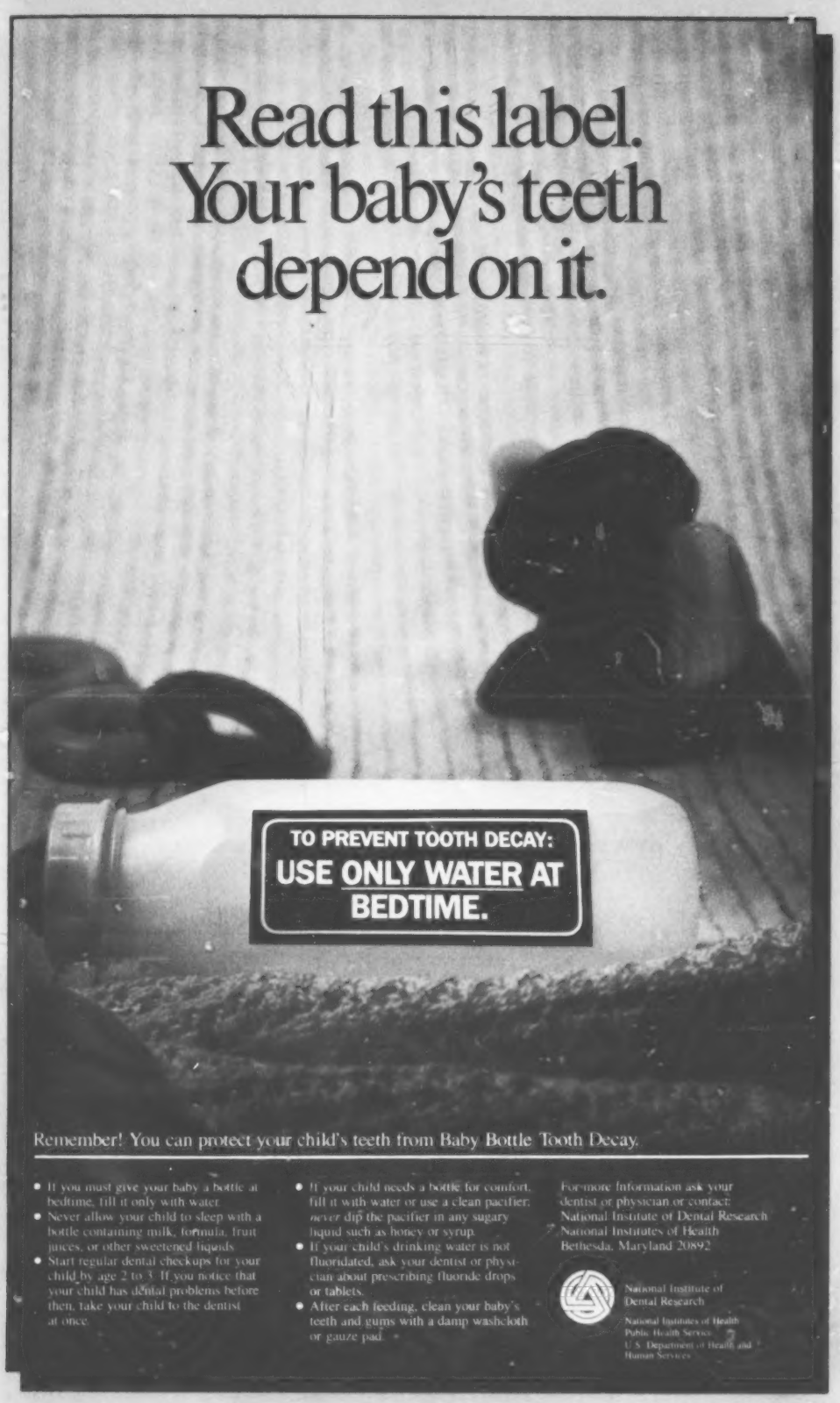
Milton F. Shore, Ph.D., is a psychologist with the National Institute of Mental Health.



Museum of Science and Industry Basic List of Children's Science Books, 1973-1984

Compiled by Bernice Richter and Duane Wenzel (Chicago, American Library Association, 154 pp., $9.75 plus $1.50 postage and handling. Copies available from Museum of Science and Industry, Museum Store, 57th St. & Lake Shore Dr., Chicago, Ill. 60637).

Compiled for the annual Children's Science Book Fair, this bibliography, a joint project of the Museum of Science and Industry and the American Library Association, contains critical reviews of 1,400 books published over a 12-year period for children in grades K through 12. An additional group of about 100 adult resource books designed to help parents and teachers interpret science material to children is also included. The books, divided into 17 categories, are rated on a 5-point scale, and most entries include citations to further review sources. Annual supplements are planned.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• Start regular dental checkups for your child by age 2 to 3. If you notice that your child has dental problems before then, take your child to the dentist at once.
• If your child needs a bottle for comfort, fill it with water or use a clean pacifier; never dip the pacifier in any sugary liquid such as honey or syrup.
• If your child's drinking water is not fluoridated, ask your dentist or physician about prescribing fluoride drops or tablets.
• After each feeding, clean your baby's teeth and gums with a damp washcloth or gauze pad.
For more information ask your dentist or physician or contact:
National Institute of Dental Research
National Institutes of Health
Bethesda, Maryland 20892
National Institute of Dental Research
National Institutes of Health
Public Health Service
U.S. Department of Health and Human Services

Preventing baby bottle tooth decay is the goal of a new full-color poster—reproduced here in black and white—produced by the National Institute of Dental Research, NIH. Free posters, in English or Spanish, are available from Health Promotion and Science Transfer, National Institute of Dental Research, Westwood Bldg., Rm. 522, 5333 Westbard Ave., Bethesda, MD 20892.

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- **Child Welfare Liability**
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children today

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Relief Nursery page 13

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September-October 1986
Volume 15 Number 5

children today

Cover photo by Rob Romig

FYI: Infant Care Crisis . . . Test for Dyslexia . . . Family Day Care Training . . . and more **2**

Overcoming Emotional Obstacles to Independence by Marty Beyer. In addition to teaching skills for self-sufficiency, independent living programs—and foster parents and child care workers as well—should address the emotional needs of young people in foster care. **8**

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Kids and Parents Spell Relief NURSERY by Marilyn Milne. Through its intensive parent training program, the Lane County Relief Nursery in Eugene, Oregon, is achieving its goal of keeping parents and children together. **13**

Child Welfare Liability: The Need for Immunity Legislation by Douglas J. Besharov. The establishment of "good faith" immunity legislation by states would, the author asserts, make groundless or unwarranted lawsuits much less likely—and much more easily dismissed at an early stage. **17**

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Interagency Alliances Link Young and Old by Charles W. Lyons. In Pennsylvania, the aging and child care networks came together to develop a variety of programs benefiting young and old. **21**

Childhood Obesity: A NICHD Workshop Report by Patricia Blessing. Researchers examine how and why America's children are getting fatter and raise new questions about how to treat childhood obesity. **26**

Recruiting Foster and Adoptive Families: A Marketing Strategy by Ann Coyne. By using proven marketing strategies in their recruitment campaigns, agencies are more likely to attract the kinds of substitute families that they need. **30**

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The Vulnerable Social Worker
Malpractice and Liability in Child Protective Services
Troubled Youth; Troubled Families
Adoption: Parenthood Without Pregnancy
Raising Adopted Children
The Adoption Experience
This Is Me and My Two Families

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FYI / Worth Noting

Celebrating the Constitution...To commemorate the United States Constitution, which was officially signed on September 17, 1787, a Commission on the Bicentennial of the U.S. Constitution has been established to encourage individuals, organizations and federal, state and local governments to organize activities, advise them about programs across the country, and promote and coordinate activities. Through September 17, 1987, the emphasis will be on the events leading up to and including the Constitutional Convention and the adoption of the Constitution. The celebration will continue through 1988, in remembrance of the ratification process, and 1989, to commemorate the 200th anniversary of the election of the first President and U.S. Congress, the appointment of the first Supreme Court and the passage of the Bill of Rights.

In addition to collecting and disseminating information on upcoming events, the national Commission offers suggestions for a variety of civic and educational activities and projects involving the public and private sectors.

To get involved in the anniversary celebrations, the national Commission recommends working through a state or local Bicentennial commission, and it provides model legislation, proclamations and executive orders for use in creating state and local commissions. For further information, contact:

Commission on the Bicentennial of the
United States Constitution
724 Jackson Pl., N.W.
Washington, D.C. 20503.

FYI

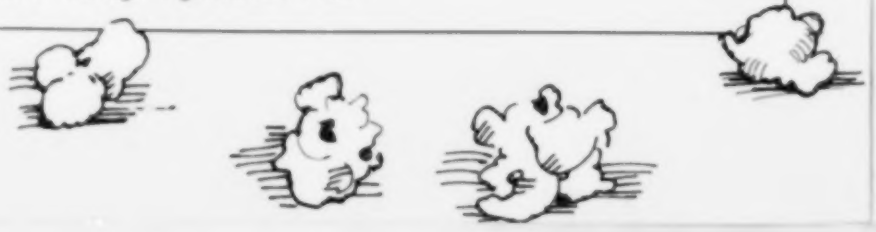
Council on Adolescent Development

Carnegie Corporation of New York has announced the creation of a Carnegie Council on Adolescent Development to generate public and private support for measures that "prevent seriously damaging problems in adolescence" and "promote healthier adolescent development."

The Council—which will be chaired by David A. Hamburg, president of Carnegie Corporation—will have a 3- to 5-year life, with a membership of approximately 16 leaders from the fields of science, law, business, government, the media, health and education, and also from youth-serving agencies. Operating through task forces of experts focusing on special issues, the Council will draw upon a wide range of consultants from the United States and other nations.

The Council hopes to explore such issues as the extent of early sexual activity, delinquency, violent behavior, drug and alcohol abuse, and school dropout among adolescents, as well as what factors within the family, economy and society place some young people at higher risk of developing these problems than others. Also assessed will be ways the media may be used to promote healthier adolescent development and how the role of such significant people as peers, mentors, counselors, teachers and parents can be strengthened in the lives of adolescents.

MUNCH IT! At home and at the movies, American children love to eat popcorn. Now, children in England and Japan are getting a taste of it, too, through efforts by the U.S. Department of Agriculture's Foreign Agriculture Service to introduce overseas consumers to popcorn and such other all-American favorites as chocolate chip cookies and peanut butter. USDA photo by Diana M. Henry.



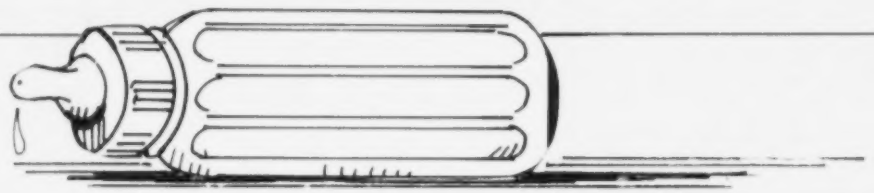
PSAs Promote After-School Programs

Three public service announcements (PSAs) dramatizing the need for after-school programs for school-age children have been produced by the School-Age Child Care Project of the Wellesley College Center for Research on Women and WFSB-TV, Hartford, Conn.

By contrasting scenes of children home alone with ones of children enjoying lively activities in a child care setting, the 30-second PSAs communicate the theme stated at the end of the announcements: "After-School Programs: Where Learning Doesn't Stop."

The PSAs are offered at $20 each to interested community groups, together with printed suggestions for approaching local TV stations about broadcasting the announcements. The PSAs, on 1-inch or ¾-inch videotape, and information are available from the School-Age Child Care Project, Wellesley College, Center for Research on Women, Wellesley, Mass. 02181.

FYI Reports



Solving the Infant Care Crisis

Some 4½ million mothers (almost 48 percent) of children under three years of age were employed or seeking work in 1984. Between 1970 and 1984, the number of mothers returning to work while their babies were less than a year old increased by 95 percent, a higher rate of increase than for any other age group. At these rates, by the year 2000 four out of every five American infants under age one will have a mother in the labor force. Only an estimated 40 percent of working women in the United States are currently entitled to paid maternity leave, typically as part of temporary disability leave and generally lasting only four to eight weeks. A largely unmonitored and insufficient supply of out-of-home child care for infants and toddlers and the potential for serious developmental damage to children who do not get adequate care in the earliest years of life have created a child care crisis in this country for millions of infants and toddlers and their working parents.

These are among the statistics and conclusions highlighted in *The Crisis in Infant and Toddler Care*, a report prepared by the Ad Hoc Day Care Coalition that documents the crucial need for high quality child care for children under age three and suggests directions for action by employers, communities and government to meet the child care crisis. The Washington, D.C.-based Coalition consists of representatives from diverse private organizations concerned about day care issues and programs and services available to children and families. Coalition members which support views expressed in the report include the American Academy of Pediatrics, Children's Defense Fund, National Black Child Development Institute, National Center for Clinical Infant Programs, National Parent Teachers Association, National Urban League, National Women's Political Caucus, The Children's Foundation, Women's Equity Action League, and National Board of the YWCA of the United States of America.

Child care centers and resource and referral agencies across the country indicate that 75 percent of all calls are likely to be requests for infant care. According to the 19-page report, many metropolitan areas have only one or two child care centers which accept infants, and these centers generally have long waiting lists. Statistics reveal that single mothers, who are more often employed than married mothers, have restricted choices given their economic need to work and the inadequacy of both parental leave policies and child care support.

Using current data and information from the Bureau of Labor Statistics, other federal government reports, child care centers and resource and referral agencies around the country, the report points out that of children in non-relative, out-of-home care in 1982, 75 percent of those under one year of age and about half of those under age three were cared for in another home—most commonly a

family day care home—while their mothers worked. Less than six percent of working mothers' infants under a year old and less than 12 percent of 1- and 2-year-olds were cared for in nursery schools or day care centers in 1982. A 1983-84 survey of state and local child care regulatory officials estimated that family day care accounted for 80 percent of all out-of-home care for infants.

The report stresses that much of family day care is unmonitored. While staff-child ratios, the size of the groups in which infants and toddlers are cared for and specialized training of child care providers are effective indicators of the quality of a child care setting, state regulations for day care centers serving infants and toddlers are usually inadequate with respect to ratios, group sizes and training requirements. Only an estimated 25 percent of the total number of family day care providers—who offer the bulk of care for children under three not provided by relatives—are licensed.

Federal, state and community action is recommended to improve existing programs and spearhead new initiatives. The report asserts that a cooperative effort by child care advocates, providers and policymakers is essential to increase options for parental leave, expand the availability of child care for infants and toddlers, enhance the quality and affordability of child care, promote training and professional recognition of child care providers, and encourage consumer awareness in the selection and monitoring of child care.

Copies of *The Crisis in Infant and Toddler Child Care* are $2.50 each from the National Association for the Education of Young Children, 1834 Connecticut Ave., N.W., Washington, D.C. 20009.

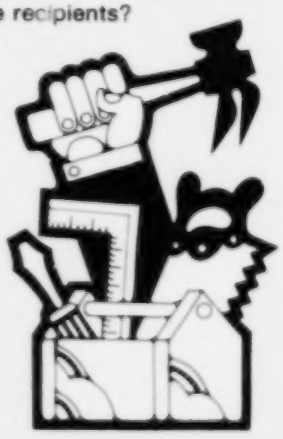
Workfare Report Cites Modest Benefits

For the past 25 years, administrators, legislators and academics have debated the appropriate design of the nation's welfare system, especially Aid to Families With Dependent Children (AFDC), which primarily provides assistance to single-parent families. A central question has been whether welfare programs should continue to be structured as broad entitlements, with aid determined by categorical eligibility and income, or instead be reshaped to impose obligations for recipients to perform unpaid work—"workfare"—or to participate in such employment-related activity as job search or skills training.

The Manpower Demonstration Research Corporation (MDRC) has released *Work Initiatives for Welfare Recipients: Lessons from a Multi-State Experiment*, a report on interim data from 11 state projects that suggest that some work relief programs can modestly benefit recipients while also somewhat lowering AFDC program costs. The 28-page monograph is the result of a 5-year social experiment, the Demonstration of State Work/Welfare Initiatives, that was launched by MDRC in 1983 to examine new state initiatives to restructure the relationship between welfare and work. States are doing this by introducing participation requirements, in addition to changing the mix of employment services and the institutional structure for administering the Work Incentive (WIN) Program, the federal work and training program for AFDC recipients.

Demonstration locations include such large cities as San Diego, Baltimore and Chicago, and a number of multi-county areas that span urban and rural centers in Arkansas, Maine, New Jersey, Virginia and West Virginia.

The study addresses several key questions about the feasibility and effects of the new programs that also speak to the design of future welfare policy. Among them: Is it feasible to impose obligations or participation requirements as a condition of receiving welfare? How do welfare recipients themselves judge the fairness of mandatory requirements? Do the state initiatives reduce the welfare rolls and costs and/or increase employment and earnings? How are costs and gains distributed between "taxpayers" and welfare recipients?



Among the pivotal issues in the workfare debate is the nature of the work slots. In examining the state workfare programs, Principal Investigator Judith M. Gueron, author of the monograph, found the jobs to be generally entry level positions in maintenance or clerical fields and park or human services, and that overall, they did not improve

participants' job skills. However, placements were not "make-work," either: supervisors indicated that participants' work was important and a large portion of participants were satisfied with their assignments and felt they were treated like regular workers.

Another source of debate in the workfare controversy is the impact of the work experience on participants' ability to gain employment and increase earnings. Examining these issues, Gueron found moderate gains in employment for recipients but mixed results regarding AFDC savings. In San Diego, a program of mandatory job search followed by short-term workfare increased employment rates by three to eight percent. Participants' average total earnings over 15 months rose by $700 per person, representing a 23 percent increase over earnings of those who did not participate.

In an Arkansas program in which job search was followed by short-term workfare, employment increased by three to five percent per quarter—an employment gain of one-third over the controls. After nine months of the program, 57 percent of the workfare participants were receiving welfare, compared with 64 percent of those in the control group. In Baltimore's workfare program, the employment rate of participants also increased by three to five percent and individual earnings rose by $176 over 12 months.

Gueron emphasizes that in judging the modest cost benefits gleaned in the San Diego, Arkansas and Baltimore programs, "even relatively small changes —multiplied by a large number of people—may have considerable policy significance." She concludes: "If only the programs' effects on the budgets are considered, the results reveal a mixed picture: savings in some states for some target groups, but not for others. But while the impacts may not be striking, they appear large enough to justify the programs' costs if a broad view of the benefits to society is taken. Some will argue that what is needed is not requirements but jobs and investments in training and intensive programs that may help people find the kinds of work that confer economic security over the longer term. The case for or against workfare may involve not so much a tradeoff between welfare savings and coercion as an opportunity to change the values, politics and perceived fairness of the welfare system."

Copies of *Work Initiatives for Welfare Recipients: Lessons from a Multi-State Experiment* are $8.00 each and can be obtained from the Manpower Demonstration Research Corporation, 3 Park Ave., New York, N.Y. 10016.

FYI/Resources

New Test for Dyslexics

A new test called the Decoding Skills Test (DST) that can diagnose specific reading disabilities in children and adults has been released in kit form, reports the National Institute of Child Health and Human Development (NICHD). The test comprises several tests that can measure competence in various "decoding" skills necessary for proficient reading. Decoding is the process by which a reader recognizes written letters (t,k,z), letter-sounds (th, sh) and words.

The DST was designed by Ellis Richardson, Ph.D., of the Nathan Kline Research Institute, Orangeburg, N.Y., and Barbara

DiBenedetto of City University of New York, under a 3-year contract with NICHD. Although it was developed primarily as a research tool to bring uniformity to the testing of dyslexia subjects nationwide, the DST is also expected to be used in the development of new methods to treat dyslexia, which affects an estimated five to 15 percent of American students. (See "Facts About Dyslexia," CHILDREN TODAY, November-December 1985.)

"Clinically, the DST will allow teachers, reading counselors and psychologists to pinpoint specific deficits in individuals who have persistent reading problems despite average or better intelligence, and help them develop methods to overcome those difficulties," says Dr. James Kavanagh, associate director of NICHD's Center for Research for Mothers and Children. He adds that uniform use of the DST by dyslexia researchers across the country will allow NICHD to compare their findings in a meaningful way, and it will help them in the testing of new hypotheses on dyslexia.

The DST measures a child's ability to read aloud (decode) words that are representative of the reading levels of most beginning reader programs. It also illustrates the individual's ability to use vowel, consonant, and syllabic patterns to transfer these skills to the decoding of unknown words, and provides measures of oral fluency. The DST was pretested on more than 1,200 elementary school children in Atlanta and New York, and its contents have been derived from a variety of classroom materials currently in use in grades one through five.

More information about the DST is available from York Press, Inc., 2712 Mt. Carmel Rd., Parkton, Md. 21120. A detailed discussion of the test by Ellis Richardson appears in the book *Biobehavioral Measures of Dyslexia* (York Press, 1985).

What Works in Education

The U.S. Department of Education has published *What Works*, a booklet for parents, educators, administrators and legislators that summarizes research data on teaching and learning and is intended to provide accurate and reliable information about what works in the education of children.

Compiled by the Education Department's Office of Educational Research and Improvement, the 65-page publication is divided into sections on home, classroom and school and presents 1-page research findings in 41 areas of educational development. Among the topics discussed are early writing, reading comprehension, getting parents involved, storytelling, school climate and discipline, learning mathematics, student ability and effort, tutoring, homework, rigorous courses, study skills and extracurricular activities.

Stressing a common sense approach and written in layman's language, the booklet includes supporting graphs, statistics and references from prominent educational researchers for each topic cited. Scattered throughout the report are quotations on education from such famous historical figures as Plato, Horace and Benjamin Franklin.

Free copies of *What Works* can be obtained by writing the Consumer Information Center, What Works, Pueblo, Colo. 81009.

FYI /Training

Teen Mothers and Employment

While teenage pregnancy is now recognized as a major social problem in the United States, resources that center on the issue of teen mothers and employment are often limited in scope, too complicated for the reading levels of many teen parents, or do not address their special circumstances.

To meet the need for an employability guide that addresses the unique, diverse circumstances of teen parents, the Manpower Demonstration Research Corporation has published *Training for Transition: A Guide for Training Young Mothers in Employability Skills*, a publication for practitioners and organizations seeking to improve employment services and assistance offered to teen mothers in

their agencies or communities. Funded by the Office of Adolescent Pregnancy Programs, DHHS, the book is a resource to help staff structure program activities in which young mothers are trained to make the most effective use of services available to them in attaining self-sufficiency.

Training for Transition is organized into three sections. The Introduction highlights the economic, social and employment problems faced by teen mothers. Chapter 2 describes a number of "learning opportunities"—including field trips, "job shadowing," guest speakers and occupational skills training—that trainers can use in preparing young mothers for employment and a sampling of the resources they can draw on in developing their activities. Chapter 3 features detailed material for one mode of learning—group training—and contains 36 training sessions that all follow a standard format. These are grouped into five core sets that encourage teens to learn more about their own needs and interests; master basic knowledge about finding a job; become familiar with the world of work; manage home and job responsibilities; and deal with changes in their roles as both mothers and workers.

Chapter 4 assists trainers in reviewing their own techniques, sharpening their skills and, where appropriate, acquiring newer ones. It is stressed that because time and resources are limited in most programs for teen mothers, trainers must utilize resources efficiently and at the outset prepare to capture and maintain the interest of those who are in the program for a limited time. Illustrating that the guide is intended to offer options, not a blueprint, it is also noted that although the training sessions have been designed with teen mothers in mind, young fathers can also benefit from much of the same information and guidance, with lessons adapted accordingly.

Copies of *Training for Transition* are $12.00 each and are available from the Manpower Demonstration Research Corporation, 3 Park Ave., New York, N.Y. 10016.

Family Day Care Training

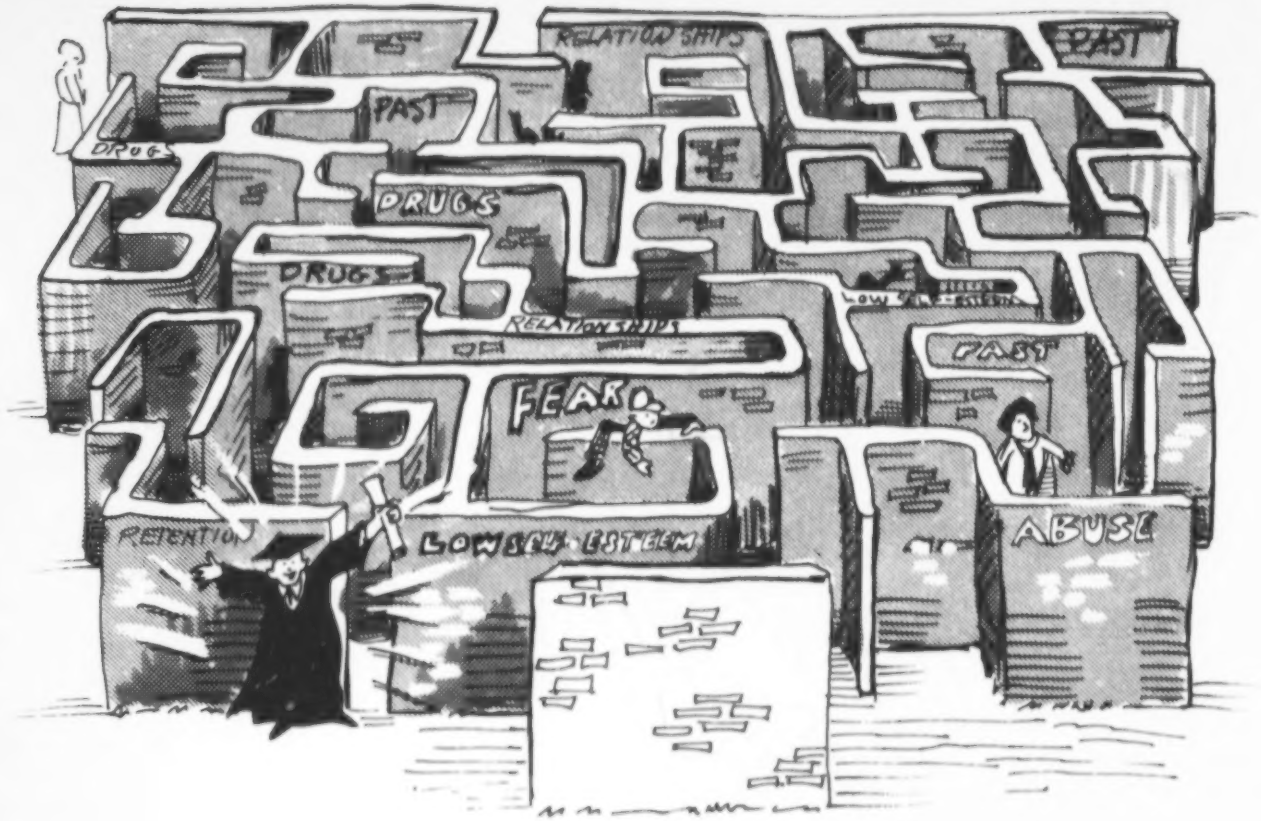
A training program aimed at the estimated two million family day care providers in the United States has been produced by the Frank Porter Graham Child Development Center of the University of North Carolina at Chapel Hill.

Developed under a grant from the Carnegie Corp., the independent study course is built around 13 information packets covering various aspects of child care, including running the family day care home as a business, arranging the home for child care, working with parents, locating community resources and serving school-age children and children with handicaps. Family day care providers also learn about child health and safety, stimulating play activities, positive methods of discipline and nutritious foods.

Each packet contains several items—booklets and pamphlets, learning activities for children, handouts for parents, a list of free or inexpensive materials to order and a user's guide, for example.

A training manual is available for state agencies and other offices that train day care operators. State agencies are also encouraged to add their own materials on specific regulations to the packets.

The Family Day Care Education Series—$21.95 for all 13 packets; $1.95 for single copies—may be ordered from Toys 'N Things Press, a division of Resources for Child Caring, Inc., 906 N. Dale St., St. Paul, Minn. 55103.



Overcoming Emotional Obstacles to INDEPENDENCE

by Marty Beyer

Permanency means an enduring safe home for every child. The final step in the process is the young person's successful move into independent living. For some adolescents who grow up in foster care, this transition is relatively smooth. Their foster families help them mature emotionally and socially so that they are able to manage adult financial and interpersonal responsibilities. However, other adolescents have great difficulty moving out on their own. They get jobs and leave them after a few weeks; they are argumentative with adults and act unpredictably toward roommates; they abruptly move in with an older boyfriend or girlfriend, only to leave equally suddenly. They frustrate foster parents, child care workers and staff of independent living programs who cannot understand their lack of success in moving toward self-sufficiency.

These young people do not benefit from independent living programs or life skills training, and they do not find stable employment. Independent living programs have much more success when they are designed to enable youth in care to overcome the emotional obstacles to independence as well as learn skills for self-sufficiency.

Young people who are unable to move out on their own successfully have not made peace with their biological families; their low self-esteem is paralyzing; they lack a reliable strong relationship; they have unresolved identity problems; and they have little mastery of their feelings. Caseworkers, foster parents and child care workers in group

homes and independent living programs can play a crucial role in helping adolescents overcome these emotional obstacles by providing a therapeutic environment in which they feel supported while their emotional development catches up with their chronological age.

Lisa and Ricky exemplify the difficulties of many children who grow up in care.

Lisa was removed from home at age eight after the death of her mother. Her father is an alcoholic whom she held responsible for the loss of her mother. After two years in foster care, Lisa was placed with her older brothers and later, as an adolescent, she began reacting strongly against their violent, unpredictable lifestyle. Lisa became promiscuous and used drugs, arguing that these were her only ways to withdraw from home. Now, at age 19, Lisa talks about moving out on her own and cutting her ties to all family members. However, she does not attend her vocational program regularly and is not making progress toward independence.

Ricky, 18, moves among five homes: a former foster family, his divorced parents, and two group homes; he spends two or three weeks in each place before getting into a disagreement and moving on. His mother has periodic psychiatric hospitalizations and his father is a drug addict. Ricky and his sister moved back and forth between foster homes and their parents throughout childhood. He has been out of school since age 15, when he left a residential treatment center. Ricky is a loner; he listens to music and generally stays out of everyone's way. He has no plans for the future.

Lisa and Ricky have several characteristics in common: poor relationships with peers and adults; a tendency to seek nurturance from biological families that experience has shown will not be forthcoming; confusion over their feelings; years of school failure; and no view of themselves in the future. Without special help, Lisa, Ricky and other young people like them cannot become independent.

Making Peace with the Past

Although Ricky's and Lisa's lives remain dominated by the trauma of childhood rejection, the shred of self-esteem that they do have derives from their attachment to their biological parents. Their original family is their lifeline, regardless of the inadequacies of that home. Even for the child who has had only intermittent contact with one or both biological parents while in care, this connection is far more significant than is often recognized.[1] While this allegiance to biological parents may be difficult for many workers and foster parents to accept, we will not be able to help children develop a balanced view of their pasts unless we do so.

Many young people who have grown up in care are very protective of their biological families—they cannot tolerate any criticism of their parents. For some, this "blind loyalty" has been created by repeated separations and consequent idealizing of the unavailable parent. However, these same young people often harbor tremendous rage against their birth parents for their failure to be responsible caretakers, for having abandoned them and for saddling them with long-lasting emotional problems.

The scars of childhood losses reemerge during adolescence. They are apparent in Ricky's and Lisa's victim mentality—what has been called "a lifetime sense of having been cheated of one's entitlement."[2] Making peace with the past means answering such questions as "Why did this happen to my family?" and "Why did this happen to me?" It means acknowledging both the anger at having been hurt by parents and the continuing importance of the biological family.

Foster parents and workers help children make peace with the past by enabling them to change their view of themselves as victims. The goal is to help them say for themselves: "My family hurt me very badly because they had problems. For years I was angry at them for what they took away from me. I wanted them to give me the love I missed. Now I see that they don't know how. I still love them, but I know they had big problems themselves. I'm grown up now, and I don't need to be a victim anymore. I can leave the past behind and take good care of myself and be loved by other people. When I get hurt by someone now, I don't have to relive all the hurts of the past."

Resolving Identity Issues

Normally, during adolescence young people both identify with and push away from their parents. But young people like Lisa and Ricky have profound identity problems—their relationships with biological and foster parents (and workers) do not permit the usual process of identification and separation.

For many young people, the most constant adult in their lives has been a biological parent. Young people often identify with that parent despite the availability of more desirable role models in the foster home, school or elsewhere. The young person may look like the parent, be

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Being good at something is the best antidote to low self-esteem. . .

temperamentally similar to him or her and have feelings about family roots that are difficult to put into words. Too often workers and foster parents, hoping to reduce the pain of identification with inadequate biological parents, have not helped young people struggling with this dilemma. We tend to respond with "Look at whom you can become" rather than encourage them to face the harder problem of "Look at what you have come from."

A victim identity enables the young person to justify long-term personal powerlessness by blaming it on childhood rejection. Being a victim means that the young person does not have to take responsibility for oneself, contrary to the maturing process that independent living programs promote. An essential part of helping youth in care with identity issues is enabling them to feel safe discarding the victim identity.

These young people believe their biological families establish a ceiling on their future, which prevents them from having more success than their parents. They view success as a criticism of their families' limitations. On the other hand, not escaping the family pattern is passively punitive and, ironically, may be the youth's way to get back at the parent. Thus, fulfilling their destinies as failures serves the dual purpose of protecting their families and expressing their anger at them.

Often biological families have no way of giving their blessing to the success of the youth in care. In mainstream culture, such events as religious rituals and high school graduation give the parent an opportunity to convey to the adolescent, "We do not need you to be just like us." Foster parents and workers cannot recognize the youth's success on behalf of the biological parents; he or she needs recognition from the biological family as well. We can help young people in care reach their potential by discussing their feelings of guilt about achieving more success than their biological families.

Improving Self-Esteem

Low self-esteem both results from and contributes to lack of success. Inconsistency and unpredictability during childhood can result in poor early adjustment in school with lifelong consequences for self-esteem.[3] Both Lisa and Ricky were distractible in class and were delayed in developing reading and arithmetic skills. Consequently, both had behavior problems in school and became truants before they reached junior high school. Their early failure in school made them dislike themselves, confirming many of the messages they were receiving from the world around them. Their low self-esteem caused them to withdraw, cutting off any chance of success in school.

Neither Lisa nor Ricky has been really good at anything. They approach situations feeling inferior, although often they cover their lack of confidence with an image of "looking good." Their inexperience with competence and their expectation of being inadequate also contribute to their inability to see themselves in the future. If either had a talent that had been encouraged, he or she might imagine the possibility of a future pursuing that ability.

In order to improve their self-esteem, Lisa and Ricky, both members of minority groups, must also come to terms with racism and sexism. Child care workers must help young people see their own potential in a culture in which they feel inferior and which often denies minorities access to success. Although oppression is a real obstacle, Lisa and Ricky can have much more control over their own success than they believe.[4]

Each young person needs to be successful at something, which means that he or she must receive encouragement to pursue it long enough to develop competence. Being good at something is the best antidote to low self-esteem—and usually leads to developing several skills. The key element of self-esteem building is action: learning something new; being recognized for an accomplishment; helping someone more vulnerable.[5] These active steps are especially needed to help young people give up their helplessness and think of themselves in the future.

Young people must have a sense of self-worth before they have the necessary confidence to get out on their own. Child care workers and

foster parents can help them appreciate their own uniqueness and support their feelings of control over their own lives. They can also serve as role models and offer opportunities for the adolescent to achieve successes.

Forming Trusting Relationships

Children can only learn the rules of friendship, the meaning of affection and the tolerance of anger and disappointment through their connection to a reliable, loving adult.[6] Some young people who have grown up in care would say that their lack of trust has been an important survival skill. They have never learned the give and take of relationships. They have not been permitted to depend on others to get their needs met consistently, and they are chronically hungry for the nurturance they missed in childhood. As adolescents, they stubbornly resist closeness with anyone, fearing more disappointment.

Such young people are at high risk for substance abuse and early pregnancy. Many adolescents describe feeling high in the same way adults would describe a close relationship—it makes them feel good, it makes them not worry, it makes them feel that they belong. Youths use drugs and alcohol as antidepressants and substitutes for forming intimate relationships. Young mothers describe a similar sense of feeling good and belonging when they have a baby, at least initially.

As they "age out" of care, adolescents like Lisa and Ricky are presented with a double bind. On the one hand, they are expected to take steps that may seem to them like breaking relationships—they are losing their foster families and workers, and they may be leaving school. On the other hand, they are encouraged to establish new relationships, while most other adolescents are allowed to take their family ties into adulthood. No wonder that vulnerable adolescents are untrusting and do not want to risk getting hurt in a new relationship.

Adolescents must be able to trust others so that they can develop a support network of productive relationships when they are on their own. Many caseworkers, foster parents and child care staff have been trained not to form too close a bond with the young person because of the potential damage from loss should that adult move out of the youth's life. Furthermore, because of their lack of trust, these young people can be very rejecting and fight against forming any deep attachments. Anyone who offers a relationship is threatening their protective detachment. Despite these dangers, however, probably the most important help we can offer the young person is a transitional relationship as he or she moves into independence.

It is crucial that the young person learn to give and take in a relationship with a responsible person—a mature peer, foster parent, child care worker, teacher, coach or therapist—and we must help the youth find this special relationship. Helping young people form good peer relationships requires coaching and considerable support. A close peer friendship is a crucial contributor to self-esteem and may be the youth's first step into successful, trusting relationships.[7] For each case, we must ask ourselves whether we have taken the steps necessary to help the young person become involved in a positive relationship as he or she makes the transition to independence.[8]

Understanding Feelings

Many youth in care are terrified of the mysterious underworld of feelings. They do not have labels for their internal reactions and often experience all their feelings as a generalized anger/anxiety state. They are scared when their reservoir of anger from repeated loss overflows under the stress of relatively minor frustrations—whether they hold the anger in or explode, their feelings are unpredictable and frightening. Underneath the anger is hurt, which makes young people like Ricky and Lisa particularly vulnerable to additional disappointment and mistreatment. In addition, a common problem among emancipating youth is chronic depression.[9]

In order to become independent, young people must learn that their feelings are not good or bad but a reality of everyday life. Child care workers and foster parents can help them moderate both their depressions and explosions by teaching them how to choose to express their feelings, depending on the situation. They need patient instruction on how to predict their feelings, particularly the anger and hurt that result from disappointment, and they also need support to overcome their depression. Adults who model mastery of feelings and are willing to share with young people how they feel and what they choose to do with their feelings can be a great help.

Developing Independent Living Programs

It is crucial that foster care agencies redirect efforts to insure that young people facing emotional obstacles to independence receive the special assistance they need.

A recent survey of more than 50 independent living programs in the United States and Canada conducted by the Institute for Quality

Child Welfare Services identified 25 program elements and grouped them into concrete and non-concrete items. Although some of the non-concrete items were found listed in many program descriptions, they were usually secondary to the teaching of life skills, employment preparation and other more concrete skills.[10] The non-concrete items were identified as:

- Decision-making.
- Developing self-identity and self-esteem.
- Accepting responsibility.
- Making peace with family.
- Developing relationships.
- Learning appropriate responses to authority.
- Developing realistic expectations of self.
- Dealing with loneliness.
- Opportunity for controlled experimentation (failure, poor judgment).
- Developing a support network.

Staff at independent living programs ranked building self-esteem and developing self-identity and decision-making skills as essential in their work with youth. The recognition of the importance of these less concrete services as the focus for many youth in care is growing as experienced program operators report on their achievements.

Recognizing the emotional obstacles to independence for some youth, foster parents, child care workers and caseworkers should work together to give the young person the permission they need to mature: permission not to blame oneself for the hurt of the past; permission to succeed; permission to feel anger and sadness; permission to see the strengths and weaknesses of the biological parents; and permission to separate from parents and other adults.

In the context of permission-giving, we can help the young person imagine and take steps toward a future in which he or she will be competent at something and able to safely create his or her own family (which is not doomed to break apart or fail to meet the needs of its members as his or her own family did). We can count as a success a young person who can say, "I see that my parents wished that our family could have been different. Now I can take charge in my own life so that it does go in a different direction."

In order to become independent, young people must learn that their feelings are not good or bad but a reality of every day life.

In a permission-giving independent living program, attention is also paid to the needs of foster parents, caseworkers and child care workers, who need regular support for their work. When adolescents who have been victims all their lives get permission to feel entitled to more, the resulting bitterness for that deprivation may be taken out initially on caring adults. Foster parents and workers need to be refueled so that they can tolerate the ups and downs of the adolescents' struggles.

To make progress toward independence, a young person must be comfortable discussing family relationships, feelings and hopes for the future. A regular group meeting in which these topics are openly discussed among young people is essential in residential and day programs aimed at helping youth toward independence. Young people benefit from realizing that others are experiencing the same painful process of enhancing self-worth, investing in the future and revisiting the past. The best way to help youths take their emotional development seriously is by doing so ourselves as we implement independent living programs. ■

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[2] B. Schachter, "Treatment of Older Adolescents in Transitional Programs: Rapprochement Crisis Revisited," *Clinical Social Work Journal*, Vol. 6, No. 4, 1978.

[3] V. Fahlberg, *Attachment and Separation: A Workbook*, Project Craft—Adoption Training Project, Michigan Department of Social Services and Spaulding for Children of Michigan, 1979.

[4] A. Clark, H. Clemes and R. Bean, *How to Raise Teenagers' Self-Esteem*, San Jose, Enrich, 1980.

[5] S. Gordon and K. Everly, "Increasing Self-Esteem in Vulnerable Students," *Impact '85*, Institute for Family Research and Education, Syracuse University, 1985.

[6] Fahlberg, op. cit.

[7] Gordon and Everly, op. cit.

[8] Guidelines for helping youth develop healthy relationships with adults are presented in Helen D. Stone, et al., *Foster Parenting An Adolescent*, New York, Child Welfare League of America, 1978.

[9] J. L. Anderson and B. Simonitch, "Reactive Depression in Youths Experiencing Emancipation," *Child Welfare*, May-June 1981.

[10] Author's correspondence and discussion with Helen D. Stone, Director, Institute of Quality Child Welfare Services, Nov. 1985.

Kids and Parents Spell Relief

N-U-R-S-E-R-Y

by Marilyn Milne

Eric stood on the edge of his bed, clumsily tied the rope around his neck and jumped. But he hadn't tied a secure knot in the rope and it didn't hold his weight. It came away from his neck and he knew that, like other episodes in his short life, he had done something wrong this time, too. At age four, he had failed to kill himself.

But Eric's attempted suicide was not a total failure. It jolted his mother into leaving her abusive husband, which ended Eric's physical and sexual abuse. Then Eric and his mother entered the Lane County Relief Nursery, a Eugene, Oregon, therapeutic preschool for abused and at-risk children.

Lane County Relief Nursery works to prevent and alleviate child abuse and neglect. It is helping Eric's mother break the cycle of abuse by teaching her to be a more responsible parent. It is helping Eric, too; now he knows his abuse was not his fault, and he likes himself better.

Photos: Rob Romig

Educational activities bolster the child's own experiences and prepare the youngster for school.

Marilyn Milne is a graduate student in journalism at the University of Oregon, Eugene. *© 1986 Marilyn Milne.*

The nursery's curriculum is built around activities that improve each child's self-esteem. To increase self-awareness, each child completes a pictorial autobiography—age, height, color of eyes and a self-portrait. Educational activities bolster the child's own experiences and prepare the youngster for school.

Since many of the children are victims of physical abuse, the idea of being excited or upset without hurting someone or something is a foreign idea. A major goal of the nursery is helping children learn to express feelings without resorting to physical actions.

Jeff is beginning to learn to talk about his emotions. Playing in the house area of the nursery, he seems happy. He picks up a football helmet and twirls it around. Suddenly he throws the helmet like a quarterback firing the gamewinning pass into the end zone—a well-aimed toss that arcs the helmet across the play area.

Jeff's mother, witnessing his behavior, rushes over to find out why he threw the helmet. "It made me mad," he explains. While he cannot yet control his behavior, Jeff is on his way to finding other outlets for his anger because he understands why he threw the helmet.

"We see so many changes and gains in a short time," says Maria Rodriguez, program director at the nursery. "There is definitely a positive change in the children's sense of self and behavior, and we hope that translates into better behavior at home."

All of the nursery's 72 children are from low-income homes. Most are referred by the State of Oregon's Children's Services Division. The youngsters are developmentally delayed from poor nutrition, lack of care or the absence of bonding between parent and child. Some of the children are depressed. "There's a lot of trauma," says Jean Phelps, administrator of the nursery.

While many therapeutic nurseries

At the Relief Nursery, parents and children learn non-violent ways of coping.

around the country are financed by state governments, the Relief Nursery is not. Its low budget ($70,000 for the current year), set by its 25-member board of directors, and its heavy reliance on volunteers contributed to its selection by the National Committee for Prevention of Child Abuse as one of 26 national model programs.

The nursery's five paid staff members are supplemented by 39 volunteers. Judi Brown-King, 1984 Olympic silver medalist in the 400-meter hurdles, began as a volunteer at the nursery and is now the volunteer coordinator. She trains new volunteers and supervises them as they monitor children and teach them to follow the nursery's rules.

Volunteers quickly learn to speak to the children about choices only when options are actually available. They ensure that the children taste every item served for lunch and check that they clean up their messes.

But there are times when cleaning up a work area must wait until more important matters have been settled. When 5-year-old Jana stops playing with the cornmeal in the sandbox and begins throwing the grain against the wall, a volunteer immediately leads her into the hallway for a time-out.

A time-out is the most severe punishment at the nursery, and it is deliberately non-violent. Jana is told the reason for her time-out, the timer is set (one minute for each year of age) and she serves her time. When the timer rings Jana is invited back to the group, and the incident is not mentioned again.

Most of the children think twice about their actions when they hear the simple warning, "I'll only be able to tell you this once." However, the adults in the nursery try to divert any child who is headed for a time-out. During cleanup time, a nursery employee tells several children, "Shannon needs more helpers," and Shannon is saved the frustration of cleaning up the sandbox area by herself. Brent, upset because another boy sat in the chair he had been sitting in, is heard out by the teacher, who suggests, "Can you ask him to move?" The boy moves when Brent asks him, and the tension eases for both children.

Sometimes staff creativity is challenged in other ways. "We got a dirt-encrusted 1-year-old kid," Phelps recalls. "She was totally unresponsive. She couldn't hold up her head or arms. We tried putting her by a bowl of water and letting her play with it. Now she laughs and talks."

Eric's mother realized she could change her situation. She was selected by Children's Services Division (CSD) to join other families in its Intensive Parent Training Program, which is held at Lane County Relief Nursery. Although Eric is now in foster care, CSD will return him to his mother if she can prove she has gained parenting skills from the special program.

In addition to working on goals set for her by CSD, Eric's mother must attend four days (12 hours) of instruction and role-playing. She will then spend eight Tuesday afternoons in the nursery with Eric. "These sessions bring out the real way parents and children deal with each other," Rodriguez explains.

A boy knocks some blocks off the table. Although he comes from foster care weekly to be with his mother, she has not been talking to him. But when the blocks land on the floor, she yanks his arm and says sharply, "You stop that." Casandra Firman, CSD's parent trainer, sits down at the table and the mother begins kissing her son.

Another mother, pushed past her tolerance limit by her son's lack of interest in chalk drawing, slaps his hand. "He pushes me too far and thinks it's funny," Sandra says of 2½-year-old Scott. Rodriguez, noticing the situation, asks Sandra if she slapped Scott. "There's nothing wrong with slapping him as far as I'm concerned," Sandra says, her voice rising.

Rodriguez quietly reminds Sandra of last week's discussion on pinpointing behavior and correcting for it properly. "Oh, right," Sandra agrees, "maybe I could just distract him." Mother and son soon resume drawing pictures.

After the 3-hour session, Firman and Rodriguez meet with the parents to discuss the day's events. Firman tells the parents, "Your kid is another human being who needs to be treated with dignity and respect the same as we would want to be treated." There are nods of understanding from the parents.

The group discusses good ways to tell children they can't leave the table while eating. They also contribute suggestions for distracting children rather than punishing them, and they talk about phrasing comments positively.

They role-play getting a child's attention. Cindy pretends Firman is her son. To be sure her "boy" is listening, Cindy takes Firman's jaw between her fingers and thumb and turns her "son's" head to make eye contact. "Wow, that actually didn't feel good," Firman protests. "I didn't like the way that felt."

Cindy apologizes. "I don't have much feeling in that hand, and I don't know how hard I'm grabbing."

While Cindy has learned another lesson about successful parenting, Firman knows all the parents are captive pupils. As one man says, "I'm here to get back my 6-year-old boy."

Still, the parent training sessions in the nursery are helping CSD achieve its goal of keeping parents and children together. Parents of 60 children have "graduated," and 75

Activities are designed to enhance each child's self-esteem.

percent of the children in foster care are returned home after their parents complete the training. Those children who stayed with their parents are observed in the homes, with CSD reserving the option of removing them within three months if their situations have not improved. It has not been necessary to take children away from any of the 28 parents who have completed CSD's course.

The Intensive Parent Training Program goes beyond the standard CSD parent training program, and the three sessions conducted to date have strapped the original program's budget. So Firman and other CSD staff members are sewing a quilt to sell as a fundraiser.

Like the parent program, the Relief Nursery is constantly short of its ideal funding level. Indeed, the nursery closed for five weeks in 1984 because of financial difficulties. That's when Phelps began her tenure. She had been aware of the nursery since the Junior League established it in 1976 in conjunction with CSD. She reorganized the program and went in search of grant money and donations.

Assistance comes to the nursery from the county government and United Way. Other contributions and donations of books, balloons and Christmas gifts come from local churches, service groups and individual donors. Both of the churches where the nursery is housed provide their spaces at no cost.

Even on its budgetary shoestring, Lane County Relief Nursery staff members believe they are showing parents and children ways to cope non-violently. Scott's mom agrees. In the parent training discussion groups she gives her viewpoint on the best way to handle a child hiding under a table, and she takes notes on the opinions of other parents. "I'm learning lots," she tells a CSD aide.

And Steven, crouched down by his son and daughter at a too-small table, is discovering the delicate art of balancing the needs of two children who want his attention at the same time. His son wants him to draw a bunny. His daughter is more interested in trading crayons.

Steven distracts his daughter by showing her how to put the crayons in a can, and she begins putting them in it. Steven says, "Thank you."

Then he turns to his son and draws on the paper. "There," he says moments later, "I drew a bunny." Steven's son pats the picture and grins up at his father. ■

Child Welfare Liability:

The Need for Immunity Legislation

by Douglas J. Besharov

You are a child protection caseworker, and you closely follow agency policy on all cases. After completing an investigation of a child reported as abused, your assessment is that the child will remain at home and service will be provided to the family. While the case is open, the child dies of injuries allegedly inflicted by a family member. You are called to testify about the case before a grand jury. The next day you are arrested and charged with criminal malfeasance of your public duties.[1]

In all parts of the country, social workers are being given administrative reprimands and are being fired, downgraded or reassigned for allegedly mishandling their cases. Hundreds of workers (and their agencies) have been charged with professional malpractice or violation of their clients' rights. Clients' claims for monetary damages range anywhere from a few thousand to millions of dollars.

Criminal prosecutions, though still infrequent, are also increasing. At least a dozen social workers in various communities have been indicted for official malfeasance or negligent homicide. Many others are being brought before investigating grand juries.

While it is not possible here to discuss all the types of cases that can be, and have been, brought against child welfare workers, they fall within three broad categories:

Inadequately protecting a child, including liability for failing to accept a report for investigation, failing to place a child in protective custody, returning a child to dangerous parents, and failing to provide adequate case monitoring;

Violating parental rights, including liability for unnecessarily intrusive investigations, defamation of parents, wrongful removal (or withholding) of children, malicious prosecution, and the disclosure of confidential information; and

Inadequate foster care services, including liability for dangerous foster parents, failing to meet the child's need for special care, failing to treat parents, and failing to arrange for the child's adoption.

With these and similar cases in mind, this article focuses on the need for specific legislation to provide "good faith" immunity for

child welfare workers and their agencies.

Unfair Blame

Few would deny that social workers should be held accountable for careless or slothful conduct. Everyone should be deeply troubled, for example, when a child dies because a worker overlooked or ignored signals of great—and obvious—danger. Civil and criminal liability might well deter the most egregious forms of professional malpractice.

However, in most cases, the workers were being blamed for situations simply beyond their control, for performing their professional and official responsibilities under the most difficult conditions. And, in some cases, the workers were being scapegoated for failures at higher levels of government.

In a 1980 El Paso, Texas, case, for example, a child protective worker, the worker's supervisor and the agency director were charged with criminal negligence for failing to remove a child from the home. The agency had become involved with the family when a hospital reported that a 9-month-old child had severe scald burns on the lower back and buttocks. The agency decided that the child could remain home while the parents received counseling. Ten months later the child died of apparent asphyxiation. Although the medical examiner did not attribute the child's death to child abuse, the three were indicted. One month before their trial was to begin, the judge dismissed the indictment on the ground that no indictable offense had been charged.

Blaming social workers for conditions beyond their control is simply unfair. In child protective work, most workers, R. Horowitz notes, "are just government employees doing a difficult, often unpleasant job, and because they deal with volatile, unpredictable family situations, injuries are sometimes unavoidable."[2] First, child maltreatment is inherently difficult to detect or predict. In many cases, no one is at fault. No one, not even the most dedicated and competent caseworker, could have prevented the child's subsequent maltreatment. Child protective decisions must often be based on incomplete and misleading information as important facts go undiscovered or are forgotten, concealed or distorted. Child maltreatment usually occurs in the privacy of the home. Unless the child is old enough (and not too frightened) to speak out, or unless a family member steps forward, it is often impossible to know what really happened.

In addition, some home situations deteriorate sharply—and without warning. It is easy to see the need for protective intervention if the child has already suffered serious injury. Often, however, a decision must be made before serious injury has been inflicted. Under such circumstances, assessing the degree of danger to a child requires workers to predict the parent's future conduct. The worker must predict that the parent will engage in abusive or neglectful behavior and that the child will suffer serious injury as a result. The unvarnished truth is that there is no way of predicting, with any degree of certainty, whether a particular parent will become abusive or neglectful. Even setting aside the limitations imposed by large caseloads and poorly trained staff, such sophisticated psychological predictions are simply beyond our reach.

Moreover, sometimes no decision is clearly correct. There will always be borderline cases.[3] As long as child protective decisions must be made by human beings, the chances for human error will always be present. Thus, social workers and agencies cannot guarantee the safety of all children known to them. Even if workers placed into protective custody all children who appeared to be in possible danger—a degree of overintervention that few would support—some children would continue to suffer further injury and even death because the danger they face would go undetected—or unpredicted.

Second, many child protective tragedies are the inevitable result of inadequate funding. There is not enough money to attract the most qualified workers; preservice and inservice training is largely nonexistent or superficial; the size of investigative staffs does not keep pace with the rapid and continuing increase in reported cases; and there is a chronic shortage of the mental health and social services needed to treat both parents and children.

With more cases than they can handle, poorly trained caseworkers do not have enough time to give individual cases the attention required. In the rush to clear cases, many key facts go undiscovered as workers are forced to perform abbreviated investigations. Moreover, protective agencies are rarely able to monitor dangerous home situations with sufficient intensity and duration to ensure a child's safety. The average family under home supervision receives about five visits over a 6-month period, after which the case is closed or forgotten in the press of other business.[4]

The Cost of "Winning"

Even when child welfare workers win in court, they lose. Legal vindication comes at a high price. Newspapers carry stories about the suit (usually focusing on the untested allegations); workers are often suspended, placed on administrative leave or transferred, pending resolution of the case. A trial—and all that goes with it—is confusing, stressful and time-consuming.

Legal fees have to be paid, whether one wins or loses. Lawyers' bills can range from $5,000 (when the case is dismissed quickly) to over $50,000 (when a trial and appeal are necessary). In one El Paso criminal prosecution, for example, before the charges were dropped, the indicted child protective workers incurred legal fees of $15,000—for which they were solely responsible. Rarely are victorious defendants reimbursed for these costs, although the worker's agency or an insurance policy may do so. And for long after, friends, colleagues and clients remember that the social worker's conduct, judgment and ability were challenged in court.

Defensive Social Work

The harmful effects of unfairly blaming social workers go far beyond the individuals involved. These cases are well known in the field. They—and the media coverage that surrounds them—have convinced social workers that the imposition of liability is a haphazard and unpredictable lottery having little to do with individual culpability. Ordinarily, the deterrent impact of civil and criminal liability might improve child protective practices. In the present atmosphere, however, with workers and agencies being unfairly blamed, the prospect of such liability worsens practices because it causes defensive social work.

Defensive social work leads to overintervention. Workers feel that they will be blamed if there was any reason, however minor, for thinking that the child was in danger. Hence, they are under great pressure to take no chances, and to intervene whenever they might be criticized for not doing so. The dynamic is simple enough: Negative media publicity and a lawsuit are always possible if the child is subsequently killed or injured, but there will be no critical publicity if it turns out that intervention was unneeded, and much less chance of a lawsuit. Joanne Selinske, formerly director of the American Public Welfare Association's child abuse project, characterized this approach as the " 'better safe than sorry' attitude that permeates the child protection system." [5]

No one knows exactly how much defensive social work goes on. There is no denying, however, that it affects all aspects of child protective decision making, especially removal decisions. Most observers would agree with Yale Law School Professor Peter Schuck, who states: "Social workers may more quickly —but prematurely—remove children from troubled families rather than risk being sued on behalf of an abused child." [6] L. Schultz, a social work professor in West Virginia, found in his survey of child protective workers at least one worker who "tries to get state custody of all suspected abused children just to protect herself from liability." [7]

In another state, a program director described what happened after he was indicted for "allowing" a child to be killed: "Upon learning of the indictment, caseworkers and their supervisors became aware of their own vulnerability. As a result, paperwork increased to account for everyone's actions and for a while more children were removed from their homes. Supervisors told me that these removals seemed unnecessary but that caseworkers were afraid." [8]

Ironically, this kind of defensive decision making is breeding further litigation as parents have begun to sue workers and their agencies for violating their civil rights. One Minnesota case was settled for $15,000; a Virginia case for $4,000. In several pending cases, much larger settlements—up to a million dollars—are in prospect.

"Good Faith" Immunity

Protection for workers is possible through a simple reform: They should be given immunity for their good faith efforts to serve children and families. The *Second Restatement of Torts* (American Law Institute, 1979) describes good faith immunity as meaning that the "officer is not liable if he made his determination and took the action that harmed the other party . . . in an honest effort to do what he thought the exigencies before him required."

Reflecting the need to protect public officials who must exercise their best judgment in performing their duties, state and federal law grants public officials good faith immunity for their "discretionary" actions. [9] Some court decisions go further and grant public officials absolute immunity. [10] For either good faith or absolute immunity to be granted, the official's act must have been "discretionary." All other acts are "ministerial," for which there is no immunity. A description of the difference between the two was given by the New York Court of Appeals: "Discretionary or quasi-judicial acts involve the exercise of reasoned judgement which could typically produce different acceptable results whereas a ministerial act envisions direct adherence to a governing rule or standard with a compulsory result." [11]

If the existence of immunity were solely determined by applying such word formulations, all child welfare decisions would be protected. Most courts, however, refuse to apply the discretionary-ministerial dichotomy mechanically because they realize that if they did so, it "could be invoked to establish immunity from liability for every act

or omission of public employees . . . ." [12] In most jurisdictions, deciding whether an act is "discretionary" or "ministerial" is, as the *Restatement of Torts* explains, "a legal conclusion whose purport is only somewhat incidentally related to the definitions of the two words composing it. Instead of looking at a dictionary, therefore, the court must weigh numerous factors and make a measured decision . . . ."

Case-by-case granting of immunity is supposed to lead to decisions more precisely tailored to the situations before the court. But such fine tuning is really not possible. As Schuck has convincingly shown, court rulings are usually made "on the basis of distinctions that bear little relationship to protecting vigorous decision making." [13] People familiar with child welfare services, but unfamiliar with how judges reason, will be surprised to learn that some courts have found no discretion involved in the decision to accept a report for investigation, the decision to initiate court action, and the decision to place a child with particular foster parents.

Immunity Statutes

Dissatisfaction with the case-by-case approach has already led nine states, Puerto Rico and the Virgin Islands to pass legislation granting child protective workers blanket good faith immunity for all their official actions.[14] All states should do the same. In fact, similar laws should be passed to protect all child welfare workers. The following statutory language for such a law is suggested:

Recommended Immunity Legislation

All employees of the [insert name of public agency here] **required or authorized by the laws of this state to perform child protective or child welfare functions shall, if acting in good faith, be immune from any civil or criminal liability that might otherwise result from the performance of their official duties.**

Good faith immunity does not give child welfare workers carte blanche to act wrongfully. They are still subject to liability when they act in callous or reckless disregard of their official duties. Thus, good faith immunity does not prevent the filing of lawsuits. The plaintiff can always allege bad faith so long as there is a sufficient basis for doing so. But good faith immunity does make groundless or unwarranted suits much less likely—and much more easily dismissed at an early stage. The establishment of good faith immunity would, then, be a major reform.

Judicial Action

State immunity legislation does not affect lawsuits under the federal Civil Rights Act or other federal statutes—major avenues of litigation against child welfare workers. Therefore, barring congressional action, which is unlikely, federal courts will continue to determine whether worker activities are "discretionary" on a case-by-case basis. One can only hope that federal judges will become more aware of the realities of child welfare work and, hence, be more willing to grant workers good faith immunity,[15] and that state court judges, in jurisdictions that do not adopt immunity Legislation, will do the same. ■

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[1] W. Griffin and J. Kalinowski, "Approach to Liability Concerns: Standards for Practice," *Family Life Developments*, April/May 1981.

[2] R. Horowitz, "Improving the Legal Bases in Child Protection Work—Let the Worker Beware," in W. Holder and K. Hayes (Eds.), *Malpractice and Liability in Child Protective Services*, Longmont, Colo., Bookmakers Guild, 1984.

[3] J. Giovannoni and R. Becerra, *Defining Child Abuse*, New York, The Free Press, 1979.

[4] See U.S. General Accounting Office, *Increased Federal Efforts Needed to Better Identify, Treat and Prevent Child Abuse and Neglect*, Washington, D.C., U.S. Government Printing Office, 1980.

[5] J. Selinske, "Protecting CPS Clients and Workers," *Public Welfare*, Summer 1983.

[6] P. Schuck, *Suing Government: Citizen Remedies for Official Wrongs*, New Haven, Conn., Yale University Press, 1983.

[7] L. Schultz, *Malpractice and Liability in West Virginia's Child Protective Services. A Social Policy Analysis*, Morgantown, West Virginia University School of Social Work, 1981.

[8] C. Gembinski, M. Casper and E. Hutchinson, "Worker Liability: Who's Really Liable?", in C. Washburne (Ed.), *Looking Back, Looking Ahead: Selections from the Fifth National Conference on Child Abuse and Neglect*, Madison, University of Wisconsin School of Social Work, 1982.

[9] See *Prosser and Keeton on Torts*, 5th Ed., St. Paul, Minn., West Publishing Co., 1984.

[10] See, for example, *Whelehan v. County of Monroe*, 558 F. Supp. 1093 (W.D.N.Y. 1983); *Bauer v. Brown*, Civ. No. 82-0076-L (U.S. D. Ct. W.D. Vir., 30 August 1983); cf *Tango v. Tulevech*, 61 N.Y. 2d 34, 471 N.Y.S. 2d 73, 459 N.E. 2d 182 (1983).

[11] *Tango v. Tulevech*, op. cit.

[12] *Elton v. County of Orange*, 3 Cal. App. 3d 1053, 84 Cal. 27, 29 (Ct. App. 1970).

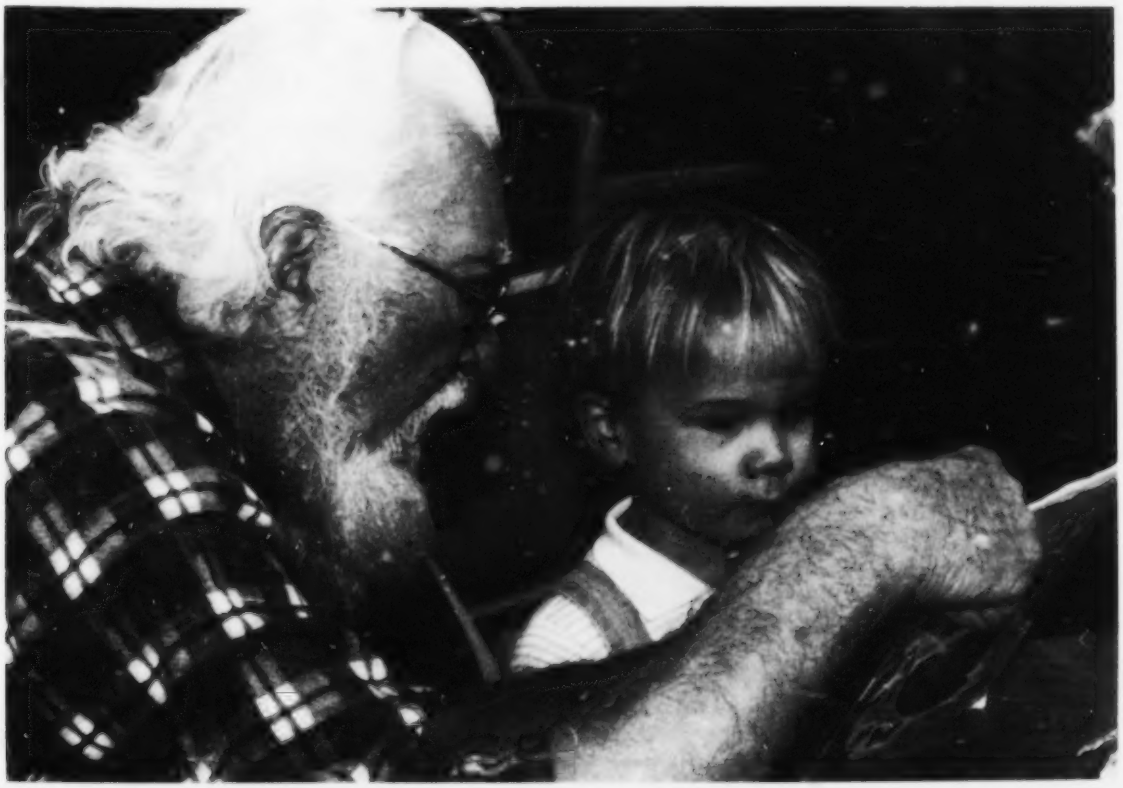
[13] Schuck, op. cit.

[14] The nine states are Florida, Illinois, Minnesota, Missouri, New York, North Carolina, North Dakota, South Dakota and Wyoming.

Absolute immunity, however, is too strong a remedy. It precludes liability even when the official's misconduct results from actual malice or a reckless disregard of legal requirements. As many cases sadly demonstrate, there are times when civil and even criminal liability may be justified.

[15] See, for example, *Whelehan v. County of Monroe*, op. cit.

Interagency Alliances Link Young and Old



A guest at the Philipsburg (Pa.) Senior Citizens Center shares a story with a youngster from Philipsburg Day Care Center. Photo: Connie Dillon/The Progress.

by Charles W. Lyons

There is growing evidence today that interactions between young children and older adults in structured environments are beneficial to both populations, having a positive impact on the growth and learning of young children and on the quality of life of older persons. Yet, despite growing evidence regarding the effectiveness of intergenerational programs for both young and old, it is not uncommon to find agencies that serve young children and older adults going their separate programmatic ways. Separated by such factors as histories, professional jargon, funding sources and location, these agencies have typically not considered themselves to be allies.

To be sure, some child care agencies or Head Start programs do plan for their children to visit the residents of a nearby nursing home or senior center for such special occasions as Halloween parades and Christmas caroling. The reality, however, is that many of these agencies just don't know how to approach their counterparts to discuss cooperative, ongoing programming efforts. It is not that they don't think intergenerational programming would be a good idea. Rather, barriers to cooperative programming usually arise because agency

staff members do not know their counterparts or recognize the reciprocal advantages of intergenerational programming, lack the time or motivation to establish interagency linkages, or simply do not know where to begin when planning a joint program with another agency serving a different clientele.

In response to these circumstances, an innovative project was conceived and implemented in Pennsylvania by Generations Together, a program of the University of Pittsburgh Center for Social and Urban Research. Entitled "Developing Intergenerational Programs Jointly with the Aging and Child Care Networks in Pennsylvania," the project was funded jointly by the Administration for Children, Youth and Families and the Administration on Aging, OHDS. Its purpose was to provide assistance to program staff from the aging and child care networks by helping them plan and implement intergenerational programs that nurture and support the growth and learning of young children and reinforce the life satisfaction and well-being of older adults. The project was also intended to contribute to the professional development of program staff by helping them develop cooperative programs that benefit the populations they serve.

It is significant that this project was developed in Pennsylvania, which has been a leader in intergenerational programming. Before this project was launched, a memorandum of agreement was established among the Pennsylvania Departments of Aging, Education, and Public Welfare addressing the need for collaboration in the development of intergenerational programs. This agreement was the philosophical and administrative cornerstone that enabled the project to reach out effectively to agencies in the commonwealth providing direct services to older adults and young children.

Objectives

Project objectives involved creating increased opportunities for interaction between young children and older adults, developing resource persons to support efforts of child care providers, and meeting the shared training and program development objectives of diverse agencies through their collaboration in an integrated training program. Specifically, the project aimed to accomplish the following:

Older adults in the intergenerational programs reported that their participation contributed to their own well-being.

- train approximately 15 staff from the aging network (senior centers, area agencies on aging, senior citizen housing sites) and 15 staff from the child care network (child care centers, Head Start programs, infant-toddler day care programs) in each of five different geographic regions of Pennsylvania (150 staff in all) to plan and implement collaborative intergenerational programs for their target populations;
- develop approximately 50 intergenerational programs involving older adults and young children throughout Pennsylvania;
- demonstrate the effectiveness of cooperation among staff from the aging and child care networks in pursuing complementary interests and needs;
- contribute to young children's growth and learning through the development of caring relationships between young children and older adults; and
- contribute to older adults' feelings of well-being through their involvement as support persons for young children.

Methodology

Four major activities were conducted to achieve these objectives.

Preparation for training workshops. Working closely with the statewide leadership of the child care and aging networks—including representatives from the Pennsylvania Departments of Aging, Education, and Public Welfare, Pennsylvania Association of Child Care Agencies, Pennsylvania Association of Non-Profit Homes for the Aged, and Pennsylvania Head Start Association—training sites were selected in each of five geographic regions within the state. Participants from each of these regions were then selected based on such criteria as interest in intergenerational programs and in collaborating with staff from other community agencies, demonstrated initiative in implementing new programs, and willingness to devote the time necessary to implement an intergenerational program. Special attention was devoted to finding pairs of staff from child care and aging network agencies that were located closely enough to enable convenient collaboration.

Staff training. The centerpiece of the project was the provision of two days of training for staff from the aging and child care networks to provide participants with the knowledge and skills necessary to develop their own intergenerational programs and to promote collaborative relationships between staff members.

Training sessions highlighted such topics as the rationale for, and benefits of, intergenerational programs; strategies for introducing the con-

cept of intergenerational programs to agency staff and potential participants; the participants' roles; maintenance and support requirements for intergenerational programs; recognition of participants; and program assessment. Training sessions featured mini-lectures, brainstorming, audio-visual presentations, role playing, group discussions and planning exercises. By the conclusion of the training period, participants had completed written intergenerational program development plans that detailed *what* needed to be done, *who* would do it and *when* it would occur.

Ongoing support to trained staff. Following the training workshops, staff members received support throughout the project in the form of telephone conferences from project staff. During these conversations, project staff helped the agency staff members review the results of their accomplishments and plan their next steps.

Follow-up support workshops. At 3- and 9-month intervals following the training workshops, full-day follow-up workshops were held to help program staff review their experiences in developing intergenerational programs, share successes and problems, brainstorm strategies for solving problems, plan for program maintenance and expansion, and develop a support network among each group of participants.

Outcomes

The project's success was measured in several ways. First, information was collected about intergenerational programs that were newly formed or expanded as a result of the project. Second, anecdotal comments about these new programs were recorded by staff, and third, evaluation forms were completed that required participants to assess the program's impact.

Not only did the project surpass its goal of 50 intergenerational programs, but participants reported on a total of 64 new or expanded programs. As the following examples illustrate, local programs reflect remarkable diversity.

- Children from child care centers visit nursing home residents and participate in music, art and movement activities with them.
- Older adults from a subsidized senior citizens residence are employed as part-time aides in a child care center located near their apartment building.
- Children from a child care center and older persons from a senior citizens center share holiday celebrations and weekly story activities, in which the elders read stories and then tell their own stories based on their childhood experiences.
- Children from a day care center located on the campus of a life care community participate in planned activities with residents of the health care center, including balloon vollyball, nature walks, painting, cooking and picnics.
- Clients of an adult day care center and children from a child day care center—both of which are housed in the same facility—engage in such integrated activities as musical programs, art exercises, table and floor games, and occasional field trips.
- Older adults from a senior citizens residence visit a child care center each month to participate in horticultural activities. In the warm weather, they plant and tend a garden on the grounds of the child care center, and at other times of the year, engage in indoor activities related to plants and gardening.
- Active older volunteers work with teachers at a child care center, reading stories, sharing snacks, comforting a crying child, listening to the children's stories and offering the children encouragement in completing work or art projects.

Reflecting on the impact of these intergenerational programs, staff of agencies serving young children and older adults often comment on the positive outcomes of the intergenerational interactions they have observed. They point out, for example, that the intergenerational project has enhanced the contentment and mental and social functioning of clients in the adult day care program as it has fostered their continued involvement in the community. One staff member commented that the residents of a retirement community "have more of a sense of family in their individual buildings."

Agency staff note that deep emotional attachments have been formed between the children and seniors and between teachers and older persons. The children openly display affection for the seniors and have special friends they look for, while the older persons involved in the program are more alert and look forward enthusiastically to the children's visits. As the children form ongoing relationships with the seniors, teachers are also enjoying the program. One teacher observes, "It is a shot in the arm for caring teachers to watch the faces of young and old light up as they grow to care about each other."

A systematic assessment of the project's impact documented its important outcomes. Based on a survey of the child care staff who received the training and subsequently implemented intergenerational programs, benefits to the children were significant. For example, 82.6 percent of the staff who returned the questionnaire reported the children's responses to older persons as positive, and 91.3 percent reported that the children benefitted

from their interactions with the older persons. Benefits for the children were reported in such general developmental areas as learning, behavior, emotional growth and socialization.

Specific areas where a majority of the staff reported positive changes in the children include talking ability and vocabulary, interest in drawing and painting, manipulative skills, self-discipline, orderliness, attention span, conforming with routines, interest in older people and self-concept.

Similarly, older adults in the intergenerational programs reported that their participation contributed to their own well-being. A majority who responded to a survey indicated that their participation had increased their amount of social contact and enhanced their feeling of happiness, self-confidence, self-esteem and life satisfaction. A total of 95.4 percent of the older participants said they would recommend the intergenerational program to other older persons.

Finally, staff from the child care and aging network agencies who participated in the project strongly endorsed its basic thesis—namely, that cooperation between agencies is an important factor in developing and maintaining intergenerational programs. Some 93.5 percent of the staff described the cooperation between their agency and counterpart agency as either good or excellent; 95.1 percent described the collaborating agency as somewhat or very reliable; and 91.8 percent felt that the development of their intergenerational program was dependent upon their collaboration.

Conclusions and Recommendations

As the evaluation results indicate, the project was very successful in achieving its objectives. The 2-day training workshops were well-received and resulted in a significant improvement in participants' knowledge about intergenerational program development. But the true test of the training is the ability of the trainees to implement what they have learned—to develop effective intergenerational programs that have a positive impact on children and older adults. In this regard, the project met or exceeded its goals.

While several factors help to explain the project's success, the involvement of pairs of staff from nearby child care and aging network agencies is the preeminent key. Beyond that, the training workshops were carefully designed and structured to help participants focus their ideas and scale them down to manageable levels. Time and again, participants were advised to plan small programs that would stand the best chance of succeeding. The training workshops also enabled participants to define what needed to be done, who would be responsible for doing it, and when it should be accomplished. This procedure helped reduce the sometimes overwhelming problem of developing a new program with a

Opposite page and below: Children from the South Side Day Care Center in Scranton, Pa., are greeted warmly by new friends at the Green Ridge Nursing Home. Photo: Angelo Rose/Scranton Times.

Photo: Angelo Rose/ Scranton Times

cooperating agency to more manageable dimensions by identifying specific tasks that participants felt competent to undertake.

In addition to the training, the ongoing support and follow-up workshops were important factors in the project's success. Telephone calls to participants communicated the project staff's concern for their progress, which encouraged them to make a serious attempt to implement their plans. Another link in the support system for project participants was the follow-up workshops that served as a forum for discussing successes and receiving suggestions from empathic colleagues in coping with obstacles.

Based on an analysis of this project's success, the following recommendations are offered to other systems considering replication of this model.

- From the outset, involve decision makers within participating agencies to establish a supportive climate for intergenerational program development and to ensure that they understand the expectations for their agencies.
- Provide adequate preparation and planning time to ensure that pairs of agencies serving both young children and older adults participate.
- Emphasize development of intergenerational programs by cooperating teams of staff from agencies serving young children and older adults in which cooperating staff persons have complementary roles and responsibilities.
- Present a systematic program implementation model which divides procedures into conceptually distinct, manageable activities.
- Provide systematic follow-up support for participants that helps them with problems and reinforces their commitment to develop intergenerational programs.
- Develop a strategy that supports the formation of local or regional networks of agencies involved in intergenerational program development.

In conclusion, it was clearly demonstrated that the approach undertaken in the Pennsylvania project provides an effective training and support model for the establishment of cooperatively developed intergenerational programs in other communities and states throughout the country. Moreover, the training provided by Generations Together motivated participants and prepared them to develop their own programs with ongoing, follow-up support. ■

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Childhood

A NICHD

by Patricia Blessing

America's children are getting fatter. And researchers at a recent workshop on childhood obesity are placing the blame on everything from genes to watching television.

At the 2-day workshop sponsored by the National Institute of Child Health and Human Development (NICHD), biomedical and behavioral scientists presented an assortment of research findings on how and why children become obese, and raised new questions about ways to prevent obesity and at what age obese children should be treated. But all workshop participants agreed that obesity among children is a growing problem that needs recognition (see, for example, "Adolescent Obesity" by Robert Wharton and Ruth W. Crocker, CHILDREN TODAY, Nov.-Dec. 1984).

Obese children face a much greater risk of developing psychological and social problems than do their non-obese peers. An NIH consensus development conference panel warned last year that obesity has adverse effects on health and is associated with high blood pressure, heart disease, diabetes and other medical problems.* Obese children are also more prone to orthopedic problems and, in severe cases, sleep apnea, than are their normal-weight peers.

Childhood obesity has "increased dramatically in the past 15 to 20 years, and it is not something that is going to go away," said Dr. William Dietz of the New England Medical Center Hospitals.

He analyzed data collected on 6- to 17-year-old children from the National Health and Nutrition Examination Surveys (NHANES), conducted between 1963 and 1980, which used skinfold thickness measurements (see box) to determine if a child was overweight for his or her age. Dietz found the number of obese 12- to 17-year-olds had increased by 39 percent during this time period. Even more dramatic was the increased prevalence of obesity among 6- to 11-year-olds—a 54 percent increase.

Obesity

Workshop Report

Contributing Factors

Television watching is a major contributor to the increased incidence of obesity among school-aged children, according to Dietz. Using the NHANES data, he found a strong relationship between television watching and obesity, especially in children aged 12 to 17. "If television watching were reduced and other activities increased, many cases of obesity in children could be prevented," Dietz said. Television watchers are less active and are exposed to more food advertisements, he noted, which may be part of the reason why there are more overweight television viewers.

More importantly, Dietz is finding that watching television affects a child's metabolic rate. In preliminary studies he found that for some children the energy required to sustain normal body functions is much lower while the child watches television. "Television viewing appears to affect energy levels in children, producing a 'hypnotic effect'," Dietz points out. He is now testing more children to see if this is common among television viewers.

While a similar effect was reported by another researcher, the cause was linked to overfeeding during infancy. Dr. David Margules of Temple University hypothesized that overeating causes a rise in endorphins, brain chemicals that are naturally produced by the body to promote sleep, lethargy and euphoria. He suggested that parents may unintentionally overfeed their newborns, which increases the release of these chemicals in the brain. Consequently, a "stuporous effect" is produced in the infant, Margules said, making it easier for the parents to care for the baby. And when parents continue to surround the child with food, he added, the child learns to overfeed himself.

Margules presented evidence for this hypothesis when he fed genetically obese or lean mice a drug that inhibits the narcotic effect endorphins produce. While the drug had no effect on the eating behavior of the lean mice, the obese mice ate less and lost weight.

This hypothesis raises new questions about the hormonal effects of overeating on obesity. Whether these brain chemicals promote overeating in humans needs further research.

Genetic Influences

Foremost in resolving the question of how children become obese has been weighing the influences of a child's early environment against what is carried in their genes. Obesity is a complex problem involving both genetic and environmental factors, said Dr. Norman Kretchmer of the University of California at Berkeley in his opening remarks.

But in a recent study, Dr. Albert Stunkard of the University of Pennsylvania demonstrated that a child's early environment alone has little influence on whether a child becomes a fat adult. Stunkard used a unique register of adopted infants in Denmark, which contains information on the adoptive as well as the biological parents of the adopted children. Using the body-mass index (see box) to measure fatness, Stunkard found a "strong relation" between how fat the adoptees were as adults and the body mass of their natural parents. He found no link between the body mass of the adoptees and their adoptive parents.

But Stunkard admits that while children of obese parents may be genetically predisposed towards fatness, they are not doomed to obesity. "Genes don't make you become obese," Stunkard maintains, but they make a person more vulnerable to environmental influences that affect body weight. For example, studies of obesity and social class reveal that women of lower economic status are three times more likely to be overweight than middle-class women.

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While all the participants echoed Stunkard's view of the importance of both environment and genetics in obesity, Dr. Roger Siervogel of the Wright State University School of Medicine pointed out that little is known about the genetic mechanisms involved. He urges that future studies aim to identify the gene(s) responsible for obesity so children who are at risk can be identified early.

Prevention

Along with the need to better understand the biological roots of obesity, workshop participants stressed treatment and prevention for those children who are already overweight. Because it is more likely that obese parents will have obese children, many participants suggested that these children be targeted early for weight-control programs. But when a prevention program should begin remains uncertain.

During the first year of life, calorie intake seems to be the only variable associated with heavier infants, according to infant studies conducted by Dr. Stewart Agras at Stanford University. Because infancy is a period of rapid growth, however, a program that deprives a child of nutrients could seriously hinder development of the brain, muscles and bones. Agras suggests that a prevention program started for children between the ages of three and five may be more feasible. Factors that have no impact on infant weight, such as activity levels and the parent's eating behavior, appear to become increasingly important as the child grows older.

Treatment

Most obesity experts at the workshop agreed that parental involvement is likely to improve a child's outcome in a weight-reduction program, and that the most successful family-oriented programs are those that include diet, physical activity and behavior therapy.

Recently, Dr. Leonard Epstein of the Western Psychiatric Institute and Clinic in Pennsylvania showed the positive effect of parental involvement in the treatment of obese 6- to 12-year-olds. He used a behavioral modification program on three groups of obese children from 150 families with obese parents. In one group, both the parent and child received a reward for weight loss. In another group, only the child was rewarded for weight loss, while the last group of children received no reward for weight loss. After eight months of treatment, all the groups had lost weight. However, after five years, Epstein found that compared to the other two groups, more of the parent-child group were not obese.

Epstein's study is one of the first behavior modification therapies that followed a child's progress over a number of years. Workshop participants encouraged more long-term studies like Epstein's to assess how certain behavior, diet and physical activity contribute to obesity in children.

Another researcher at the workshop reported on how the parents' role in treatment programs for their overweight child may change when the child reaches adolescence. Dr. Kelly Brownell of the University of Pennsylvania found that 12- to 16-year-old adolescents did better at losing weight and maintaining weight loss when both the parent and child received treatment independently.

Brownell had two groups of adolescents and their mothers receive behavioral treatment either with their mothers present or separately. In a final group, only the adolescent received treatment. He found that the most dramatic weight loss occurred after one year in adolescents who received treatment separately from their mothers. Adolescents in the other two groups regained their weight after one year.

What Is Obesity and

Because obesity involves both genetic and environmental factors, a number of sub-types of obesity exist. For example, obesity can be caused by hormonal abnormalities and genetic diseases, as well as excess caloric intake and lack of physical activity.

Generally, physicians label a person obese if his or her body weight is greater than 20 percent above ideal weight for height. Other measures of obesity, such as relative weight (a person's body weight divided by the average frame desirable for a person's weight) and body mass index (a person's weight divided by the square of the person's height) were not developed to measure fatness in children, but for adults aged 20 years or older. These measures are not applicable to fatness in children and adolescents because their normal growth accelerates rapidly during this time.

Another measurement of fatness, skinfold thickness, is also used to determine the amount of body fat. But because this measurement involves placing calipers on the back of the upper arm and other body sites to measure the thickness of fat, it is difficult to perform on infants and children.

But in addition to parental involvement, Brownell said that a weight reduction program of high quality is essential. He and his colleagues have developed a behavioral weight management program called LEARN—an acronym for lifestyle, exercise, attitude, relationships and nutrition. A major portion of the program teaches maintenance because, according to Brownell, "Dieting makes dieting more difficult."

He has found that repeated dieters regain their weight more quickly and lose it more slowly when they go on and off diets, creating what he calls a "yo-yo" effect. Brownell said the effects of losing and regaining weight may actually change a person's metabolism, making it difficult to lose weight once this cycle starts. If this cycle is begun during childhood or adolescence, the child may be faced with dieting all his life, Brownell noted.

Photo: NICHD

School Programs

Schools may play a role in the treatment and prevention of obesity in children. While more studies are needed to assess their long-term value, Dr. Guy Parcel of the University of Texas Health Science Center said that schools offer an "obvious place to intervene because of their potential for reaching large numbers of children and providing programs to prevent and treat obesity in school-aged children."

Parcel targeted school lunch programs and physical education classes as potential areas where intervention may prevent some children from becoming obese. For example, school lunches could shift away from high-fat, high-calorie foods and focus more on good nutrition and healthy eating habits. Physical education classes that are longer and more intense could also help some children from becoming overweight.

Future Research

NICHD expects the innovative ideas presented at this workshop to stimulate more research on the causes of childhood obesity. All participants agreed that identifying a biological marker is paramount to predicting which children will become obese. But because obesity not only involves a child's genes, but also his or her environment, the psychosocial aspects of obesity need to be more widely recognized and addressed. Whatever the final role these behavioral and biological factors play in obesity, obese children need treatment before their condition grows into a bigger health problem. ■

How Is It Measured?

The most reliable method pediatricians use to diagnose obesity in children is growth charts. Based on studies of large samples of children, these charts rank the child's weight and height in percentiles compared to other children of the same age. For example, if a child's weight is in the 50th percentile, half the children his age weigh more and half weigh less than he does.

A child's medical evaluation and family history may reveal a possible biological reason for the child's obesity, but behavioral factors cannot be ignored. Thus, such psychological and social influences as the family's lifestyle and food preferences and the parents' and child's perception of obesity need to be considered in managing an obese child.

Participants in the childhood obesity workshop agreed that better methods of detecting and measuring obesity in children are needed. But until such measures are developed, the immediate problem lies in treating children whose growth stage and speed of weight gain are excessive.

* Further information on the report of the Consensus Development Panel on Health Implications of Obesity is available from the National Digestive Diseases Information Clearinghouse, 1255 23rd St., N.W., Suite 275, Washington, D.C. 20037.

RECRUITING

Foster and Adoptive Families:

A Marketing Strategy

by Ann Coyne

Child welfare agencies are often faced with the need to attract families to serve as substitute caregivers for children. In their recruitment efforts, many agencies attempt to communicate with everyone who might be interested in becoming a "foster family"—a general title used to describe people who provide therapeutic or custodial care to a wide variety of children for various periods of time. However, with limited time and resources, I suggest that agencies' recruitment efforts would be more successful if they first identified the different types of foster or adoptive families needed and developed different approaches—using proven marketing strategies—to recruit each type.

Based on this premise, this article examines concepts from the fields of social work and marketing and offers suggestions on applying these to design innovative adoptive and foster family recruitment programs.

Types of Foster Families

To define different types of foster or adoptive families, I used three major variables: the family's relationship to the agency (team member or client); relationship to the child (extended family or replacement family); and skill level (therapeutic or custodial). The following six types of functional substitute families were identified:

Type 1 families function as extended family to biological parents in addition to providing substitute care for the child. They have specific therapeutic skills (in behavior management, special education or nursing) and are full members of the agency team with paraprofessional status.

Type 2 families become permanent families for children with special needs; they may adopt the child or enter contractual long-term foster care. These families also have specific therapeutic skills and work as full members of the agency team.

Type 3 foster families function as extended family to the biological parents and are part of the agency team. They do not have any special therapeutic skills, although they have good parenting skills.

Type 4 foster families also function as extended family to the biological parents and provide basic care for the child, but they are not considered part of the agency team and are frequently seen as clients of the agency. They may be a relative of the child or friends of the family. The placement may not be "optimum" from the agency's perspective, but the child is placed there or left there because of existing relationships.

Type 5 foster or adoptive families are the permanent family for a child. They are members of the agency team and provide good basic parenting, primarily to infants or children without special therapeutic needs.

Type 6 foster or adoptive families are also the permanent family for the child, but they are considered more as clients of the agency and do not have therapeutic skills. They may be relatives or foster parents of long standing to whom a child is attached. While care is not optimal, minimal standards are maintained.

Before developing a recruitment strategy, agencies should assess the number of each type of foster or adoptive family that will be needed in the coming year.

Marketing Concepts

Exchange relationships, market segmentation, targeting, marketing tools, campaigns and themes are all concepts used by those involved in marketing goods and services. They are also very useful concepts for social workers designing recruitment campaigns.

The concept of "exchange relationships"—the offering of value to another party in exchange for

value—is basic to understanding marketing. According to Kotler, "Since both parties agree to the exchange voluntarily, both see themselves as better off after the exchange."[1] Thus, social workers need to keep in mind that recruitment will only be successful if each party (agency and prospective foster family) perceives that more is being gained by the exchange than is being lost. Social workers are apt to be aware of the benefits and costs to the agency, but unless they are also able to perceive the positives and negatives of the exchange from the potential foster family's point of view, it will be difficult to design effective recruitment strategies. Successful campaigns are based on mutually beneficial exchange relationships between potential foster families and the agency.

Marketing theory uses the notion that society is made up of groups whose members are similar to one another in various ways and dissimilar from members of other groups.[2] To a marketing professional there is no such thing as the "general public." Some groups are of interest and others are not, and a large part of recruitment is deciding which groups are of interest and how to reach them with persuasive messages.

Marketing professionals typically segment the population into groups using such variables as age, race, geography, socioeconomic status, lifestyle, family size, education, occupation and user status and rate. Many of these same variables can be used to identify groups likely to contain the desired types of potential foster or adoptive families.

The most likely—and most frequently ignored—group for targeting is the extended family of the child needing placement. Grandparents, older siblings, aunts and uncles may already have a good relationship with the child and can be helped to become the type of foster or adoptive family the child needs.

A second frequently ignored group is existing foster families who may not now be functioning as the desired type but could. For example, quite a few Type 3 foster families, given specialized training, may be able to function as Type 1 therapeutic foster families. Some foster families currently being treated as clients by the agency may be able to function as full team members with agency assistance. However, it will probably be quite difficult to change a foster or adoptive family's perception from one of replacing the biological family (that is, "rescuing" the child) to one of assisting the biological family. Their motivation is apt to be quite different.

Recruitment of the frequently needed Type 1 and Type 3 families should begin by providing training to existing foster parents to increase their therapeutic skills and by changing agency policy and practice so foster parents function as paraprofessional team members.

After making internal changes, other likely groups should be targeted for recruitment. For example, we know from past research that certain people are more likely to be successful foster or adoptive parents for developmentally disabled children who don't need nursing care.[3] Based on this information an agency might decide to target certain segments of the population: people in their 30s or 40s who live in small cities, who finished 11th or 12th grade, are of lower middle-class status, have strong church connections, have children still at home but no preschoolers, and have added to their family by ways other than birth.

An agency's own experience may show that the more successful specialized medical foster families (Type 1) are people in their late 20s or 30s who live in urban areas, have some college and/or nursing training, are middle or upper middle class, are childless or have only one or two school-age children, and intend to be foster parents for only a short time (two to three years).

Based on such knowledge, agencies can then choose target groups and design messages that will appeal specifically to each group.

The tools that marketing professionals use to reach these groups are typically called the "Four P's": Product, Price, Place and Promotion.

Product

The "product" that child welfare agencies have to exchange with potential foster or adoptive families is both tangible and intangible. Of course, the tangible aspect is a particular child. However, for recruiting purposes, the intangibles—challenge, self-satisfaction, satisfaction in parenting, sense of achievement, opportunities to help another family and to learn new skills—must be communicated to prospective foster families in language they understand in the media they typically use.

Talking with successful foster families about the satisfying aspects of their work is one way for agencies to understand these intangible benefits. Another way is to create a detailed job description for each type of foster or adoptive family needed, thus clearly defining their roles and avoiding the role confusion that tends to result when agencies expect foster parents to perform as professionals but in practice treat them as clients.[4]

Price

The issue of price is exceedingly important and complex in our so-

ciety. People in our culture do not buy objects totally for their utility; many buy the intangible quality of status.

This notion may carry over to the recruitment of foster families. For example, the costs involved in caring for children with developmental disabilities, with their need for special equipment, transportation and other services, may serve as a barrier to recruiting foster families for them. However, for families motivated by the challenge and the desire to sacrifice on behalf of a disabled child, these excess costs (of both time and money) may make the child more, rather than less, attractive. Thus, knowing the motivation of potential foster families is important. To attract families from certain groups, stressing rather than minimizing the cost may be a desirable recruitment strategy. (Note how the Peace Corps uses the phrase "The toughest job you'll ever learn to love" in targeting people who are looking for a challenge.)

In other cases, the motivation may be to earn college credit or gain educational/vocational experience. Some people may see working as a therapeutic foster family as an alternative to practicing their professional or paraprofessional skills in another setting. To attract families from this group, the agency should communicate that these opportunities are available—and be able to offer a competitive salary.

Place

In marketing, place usually refers to the distribution channels through which products can be moved from the factory to the consumer, and much effort is devoted to devising strategies that make it easier for the consumer to acquire the product. The same basic concern also prevails in the marketing of services: how to organize the system so that the consumer can most easily enter into an exchange relationship with the agency.

Agencies need to look at where potential foster families live and whether they can connect easily with the agency. Should a branch office be opened? Does the agency make families feel welcome?

In addition to making it easier for families to approach the agency, the agency might also consider enlisting another agency or citizen/community group—one with which the targeted families already feel comfortable—to help with recruitment.

Promotion

While promotion might be thought of primarily as advertising in the mass media, there are four additional promotional tools: public relations, face-to-face communication, displays and "environmentals."

Unlike advertising, which promotes a short, single message, public relations is a strategy to make activities newsworthy. A newspaper, for example, may carry a feature story on a foster family, incorporating the messages the agency wants to get across to potential foster parents in the reading audience. Or a small weekly newspaper may provide space for a staff member to write a regular column about children needing homes or families who have adopted children with special needs.

To generate local coverage of your agency's activities and needs, a good first step is to get to know the newspaper reporter assigned to social welfare issues and the radio and television station's public affairs director.

Face-to-face communication is a very powerful promotional tool since it allows for both the sharing of information and persuasion to occur—and foster and adoptive parents can be very persuasive in talking with their friends and neighbors. Discussions between potential and current foster and adoptive families at agency orientation meetings can also aid in recruitment efforts.

Agency staff members might also arrange to talk with PTAs, church organizations and other groups and urge interested parents to contact the agency for further information. Since the prospective foster parent's first contact with the agency will have a profound effect, the secretary or worker who first answers the call should be able to communicate persuasively rather than just impart information. Therefore, strategies for handling incoming calls need to be seriously discussed and planned. They are usually more important in the total recruitment effort than the mass media component, and it is a mistake to spend more time worrying about media efforts than planning interpersonal communications strategies.

Posters and other promotional displays in store windows, banks, exhibition booths and shopping malls keep the need for substitute families visible. At the agency, "environmentals"—pictures of waiting children and adoption exchange books, for example—can be used in the offices and waiting rooms. Office decorations, which should be consistent with the ethnic and cultural groups you are attempting to reach, are other unconscious signs of your concern (or lack of it) and are also important parts of your total recruitment campaign.

The Campaign

Recruitment efforts should be organized into a campaign and take place over a long period of time. A campaign has specific goals, a single theme, and a beginning and an end date.

Intensive, one-shot recruitment efforts frequently are not effective in the long run and may cause chaos in an agency. People who become foster or adoptive parents usually have thought about it for at least a

year before deciding to make an inquiry,[5] and these people may be missed in a one-time blitz. In addition, a blitz may generate large numbers of inquiries from people who have not thought enough about the issue, swamping staff with questions and requests for home studies from people who are unlikely prospects.

The first step in initiating a year-long campaign is to identify your goals, both generally (educating the community about foster care and adoption) and specifically—recruiting, for example, 14 Type 1 families and seven Type 3 families in the first six months.

The second step is deciding whether to initiate the campaign yourself or to negotiate with another agency, a foster or adoptive parents' group or a citizen's committee for recruitment services. Beaman found that substantial increases in placement occurred in communities where minority adoptive parent groups were involved in the design and implementation of recruitment campaigns.[6] Another very effective model is a broad-based citizen recruitment committee which plans and organizes the entire campaign. Pasztor and Burgess suggest that such a committee be made up of people with experience in community projects (League of Women Voters, PTA, Junior League), business people with marketing and advertising experience, leaders from neighborhood or community groups, foster parents and agency staff.[7] Training for the recruitment committee is essential, since members would probably not be knowledgeable about permanency planning.

After the recruitment committee is established and trained, a theme—a succinct sentence or idea that can be used over and over again with each promotional message—must be chosen. While many themes have been used to recruit foster families, they are almost always targeted at replacement families. For example, "Room for one more," "Love is all it takes" and similar themes have been effective in attracting people who want to be substitute families, but they do not appeal to those who want to work as part of a team to keep a troubled family together. Today, as more and more Type 1 foster families are needed, these "rescue" themes are probably mistargeting our messages. In a sense we may be guilty of faulty (if not false) advertising. Unless we take very seriously the content of the themes we select, we are apt to recruit people who want to save children from "bad" families, who won't work with biological parents and who try to disrupt the children's attachments to their families so they can adopt them.

What kinds of themes might attract potential Type 1 foster families? Some that have been used successfully include "Foster families are special people—like you?" "Foster parenting, a new experience in family living" and "Families helping families."[8] Perhaps an even better theme could be chosen to relay the message that the agency is looking for people who will work with biological families, be a member of the professional team, work to keep children attached to their family of origin, and be themselves family oriented.

Since all of the agency's promotional efforts always use the same theme, it should be chosen with care. Much effort may go into deciding, for example, if "Families *Building* Families" has more opportunity for creative visuals or is more egalitarian than "Families *Helping* Families." A logo using graphic art to get across the idea of the theme should be put on all pieces of promotional material.

Once a theme has been chosen, a year-long campaign can be designed around it.[9] Each month may have a different focus and all members of families (not just parents) should be targeted. For example, an essay contest in the high school and a poster contest in the elementary school can involve children in potential foster and adoptive families, as well as potential or actual foster children. Each month the results of various activities should be monitored to assess the response and whether the campaign is reaching the right kinds of families.

By knowing the number and types of foster or adoptive families needed, by targeting recruitment efforts to reach those families who are most likely to respond and by utilizing a community recruitment committee to develop a theme for a year-long campaign, agencies are more apt to be successful in attracting and keeping the various types of foster and adoptive families that they need. ■

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[1] P. Kotler, *Marketing for Nonprofit Organizations*, 2nd Edition, Englewood Cliffs, N.J., Prentice-Hall, Inc., 1982.

[2] Ibid.

[3] A. Coyne and M.F. Brown, "Relationship Between Foster Care and Adoption Units Serving Developmentally Disabled Children," *Child Welfare*, Mar.-Apr. 1986.

[4] E.M. Pasztor and E.M. Burgess, "Finding and Keeping More Foster Parents," *Children Today*, Mar.-Apr. 1982.

[5] Ibid.

[6] T.D. Beaman, "Initiating and Developing Minority Adoptive Parent Groups," Los Angeles County Department of Adoption, 1982.

[7] Pasztor and Burgess, op. cit.

[8] Ibid.

[9] See, for example, J. Wolff and G. Corney, *How to Plan and Conduct An Effective Adoption Recruitment Campaign*, Washington, D.C., DHHS Pub. No. (OHDS) 81-30311, 1981; C. Goodluck, *Recruitment of Native American Parents: Ideas for Practice*, Denver, Region VIII Child Welfare Training Center, 1983; and *Indian Foster and Adoptive Care Manual*, Tulsa, National Child Abuse and Neglect Resource Center, 1982.

Book Reviews

The Vulnerable Social Worker

Douglas J. Besharov (Silver Spring, Md., National Association of Social Workers, 275 pp., $14.95)

Reviewed by
Joan W. DiLeonardi

This is an important and timely book, focusing on the often minimized or overlooked legal vulnerability of social workers. The many charts and reference materials allow the reader to look for issues and legal precedents in his or her own locality. Although Douglas Besharov addresses social worker malpractice in general in the introductory chapter, the majority of the book is devoted to civil and criminal legal liability in child welfare practice in agencies. Understandably, since the emphasis is on protective service and substitute care cases, much of the material is most germane to social workers employed in the public sector. This focus was chosen because, next to claims of sexual exploitation of clients, this is the most common area of claims and the area in which claims seem to be most likely to succeed. This is a fast growing and changing area of the law and one of which social workers need to become more aware.

The author clearly illustrates with case examples and case citations that child welfare social workers and agencies can be "damned if they do and damned if they don't" in the areas of reporting suspected abuse, removing children from potentially dangerous situations, providing adequate out of home care, protecting parental rights and doing adequate permanency planning.

Many of the principles in this book could easily be applied to examining liability of social workers working with other vulnerable populations, such as the frail elderly, the mentally ill and the developmentally disabled. There is sound advice for agencies and social workers, particularly in Chapter 7—"Reducing Legal Vulnerability"—which stresses, once again, good case recording and development of agency policies. Chapter 9, "Reducing Agency and Personal Stress" by Susan Besharov, a social worker, also offers practical advice on using professional skills and knowledge to soften the impact of law suits. The increasing number of lawsuits being filed in this area as well as the current crisis in liability insurance coverage make this book a "must read" for agency executives and concerned social workers.

Joan DiLeonardi, Ph.D., is Vice President for Planning, Research and Quality Assurance, Children's Home and Aid Society of Illinois, Chicago.

Malpractice and Liability in Child Protective Services

Edited by Wayne Holder and Kathleen Hayes (Denver, American Humane Association, 204 pp., $27.50)

Reviewed by
Joan W. DiLeonardi

The 14 chapters of this volume vary in perspective, length and quality. Much valuable information is presented, as well as a variety of viewpoints. Perhaps one of the most disturbing points is the juxtaposition of Holder's statements that the problem of worker liability has been overstated with Besharov's description of the development of "defensive social work" in a minority of situations. If the problem is overstated, what can be done to minimize the type of practice in which children may be removed from their parents unnecessarily in order that the worker may avoid the possibility of later litigation? Horowitz's chapter on

the legal basis for litigation, in which he presents a relatively common and innocuous type of report and presents grounds for lawsuits for any one of several possible actions of a protective services investigation, is a chilling example of the new realities of protective services practice.

Several of the articles address the issues of practice standards and attempt to define ways of providing service which will, in the event of a lawsuit, provide a defense. That they are also the best way of helping the child and family is, unfortunately, secondary here. Selection of workers, good supervisors and good documentation are stressed, but there seems little acknowledgement of the fact that in many states there are no specific education or experience requirements for protective services workers. Several of the authors acknowledge that legal mandates outstrip available resources in many localities and that this may contribute to inadequate investigations. The solutions offered are often in the ideal state and offer little practical assistance to line workers, supervisors or agency directors.

This collection of articles raises the right questions, but the most useful information it offers is in the several descriptions of good case planning, recording and documentation.

Troubled Youth; Troubled Families

James Garbarino, Cynthia J. Schellenbach, Janet Sebes and Associates. (New York, Aldine Publishing Co., 356 pp., $29.95)

Reviewed by Milton F. Shore

When child abuse is mentioned, most people think of infants or young children being subjected to physical or psychological harm. More complicated, but nonetheless of equal concern, is the abuse of adolescents. Such abuse is correlated with running away from home, suicide, delinquency and other problems. This excellent book focuses on adolescent abuse, placing it within the context of adolescent development and the normal stresses and strains within the family during that difficult time.

The authors describe in detail the Family Interaction Project, a research study of the interpersonal patterns that differentiate healthy from dysfunctional (potentially abusive) families with an adolescent. The theoretical framework is human ecology in which individual needs are studied within the context of the family and the larger socioeconomic structure.

One of the unique contributions of the study is how the 62 2-parent families were selected by community agencies as having a significant problem in their family life with an adolescent without being identified as abusive. Thus, the researchers were able to look at the dynamics of family life prior to abuse and not after contacts with law enforcement agencies, as has been done in many other research studies, enabling the etiological factors in abuse to be teased out.

The definitions of high risk for abuse were obtained from parental responses to hypothetical situations (the Adolescent Abuse Inventory). A large number of questionnaires and scales measuring both individual factors and transactional functions were then obtained and correlated with the Inventory. Unfortunately, the family system studies did not include sibling perceptions. Discrepancies in reports between parents and the adolescent could be analyzed, and the role of subjective factors and objective variables could be compared.

The data produced a wealth of information showing both similarities and differences with other findings in the literature on abuse of younger children.

One major finding was that high-risk families seem to respond to crises by restructuring the family to exclude the troubled youth. Low-risk families, on the other hand, reform relationships within the family system. Another finding revealed how externalized (as opposed to internalized) problems in adolescents were most related to problems in discipline and support and poor coping techniques. In addition, the empirical data showed how stepparenting is correlated with high risk.

The book concludes with a chapter on intervention which, although interesting and comprehensive, is not tied to the data or with the families in the study.

Funding was not available for a follow-up study. It is indeed unfortunate that such a first-rate study cannot be continued in an area that is of great importance to our society and its functioning. How much are we willing to invest in understanding and helping our youth?

Milton F. Shore, Ph.D., is a psychologist in Silver Spring, Md.

This Is Me and My Two Families

Marla D. Evans (P.O. Box 31342, Saddle Creek Station, Omaha, Neb. 68131, 87 pp., $9.95 soft cover)

Reviewed by Cecelia Sudia

The adoption and foster care fields have developed a variety of "life" books to provide background, continuing history and important documents for children who have moved from home to home. This scrapbook/journal is designed for the child of divorce who spends time in two households either as a result of joint custody or visitation arrangements.

A few pages at the beginning are devoted to the child's identity, with spaces for current and earlier photographs and a page to complete such sentences as "I'm happiest when . . .," "My worst habit is . . ." and "I don't like to talk about . . . ."

The major sections of the scrapbook are identically titled "One of My Families," in which the child records pictures of the home and family, descriptive comments about the parent, stepparent, siblings, stepbrothers or sisters and grandparents, chores the child does there, and favorite toys and activities.

The final 30 pages again focus on the child, with space to record school and holiday activities, daydreams, and favorite people and things to do.

An adult—hopefully a parent—would need to help a child complete the book, which could also be used by a counselor working with a child in this situation. It appears that the exercise would help children aged six through 15 or so, and it should also serve to bring the child's double life to the attention of the parent—with the possibility of invidious comparisons between the two home situations. The facts of divorce are not confronted directly, although they may be reflected in asking the child to record "happenings" or "scary things."

With a broader title, the scrapbook's format could be used by a foster parent or social worker with a foster child, although some additional areas would probably need to be considered.

Cecelia Sudia is Family Services Specialist, Children's Bureau, ACYF.

Adoption: Parenthood Without Pregnancy

Charlene Canape (New York, Henry Holt, 246 pp., $18.95)

Raising Adopted Children: A Manual for Adoptive Parents

Lois Ruskai Melina (New York, Harper & Row, 274 pp., $17.95 cloth, $8.95 paper)

Reviewed by Elaine J. Schwartz

Two fine books are now available to help adoptive parents decide upon adoption, pursue and realize their goal, and then assist them in their childrearing. Both books address areas that are important for the entire adoptive family and provide direction and aid in the adoption process.

Charlene Canape's book, *Adoption, Parenthood Without Pregnancy*, provides an easy-to-read, detailed picture of how to go about adopting a child. Starting with fertility issues, with recognition of the grief faced by infertile couples and acknowledgement of the reoccurrence of these feelings after adoption, the book covers how to search for an agency, independent and foreign adoptions, children with special needs, adoption by single parents, the adopted child, advocacy for adop-

tion, and other important aspects of adoption.

This is an excellent handbook on how to go about adopting today. The author is clear in her writing and supportive to the adoptive family as they consider adoption and go forward to attain parenthood. She provides accurate information on the state of the art and is objective in presenting information on agency and independent adoptions, as well as domestic and intercountry adoptions.

In addition to the narrative content, the book includes an extensive appendix that provides a state by state list of public and private adoption agencies, adoptive parent groups, single parent information and adoption exchanges. This information can be of great help to anyone interested in adoption, but it is especially useful to the individual(s) considering or in the process of adoption. This book is also a good resource for adoption workers both as a "refresher" with up-to-date material and as a reference to recommend to adoptive families.

Raising Adopted Children is a well-written, supportive and informative book on what happens after placement and what adoptive parents need to know. Lois Ruskai Melina—an adoptive parent and editor of *Adopted Child* newsletter—provides the new and old adoptive parent(s) with a wealth of information on many aspects of childrearing related specifically to adoption. She discusses sensitive areas with compassion and yet is direct in facing such issues as infertility, sexuality and unwed pregnancy in the context of an adoptive family.

In the first three parts she covers the whole range of adoption, from becoming an instant family to what happens when the adoptee grows up. In between, she discusses the issues adoptive families face at home every day . . . issues that are specifically adoption-related. There are sections on talking with children about adoption, how adoption affects the family, unresolved or renewed grief (both for adoptive parents and children), the incest taboo, contact with biological relatives, crises in adolescence, and the importance of attitude in communications. The fourth part, special issues in adoption, has sections on growing up in a minority family (including black children in white families and intercountry adoptions), serious behavior problems and special situations in adoption, such as the single adoptive parent and the very large family.

This book is replete with ideas, issues, discussions and suggestions for the adoptive family after the adoption is legalized. It addresses infant and older adoptions, special needs adoptions and plain everyday questions with good information and references. The appendix provides information on a number of important issues, such as childrearing leave, adoption benefits, wills and health and life insurance, as well as selected references on adolescence, growing up adopted, adjustment of parents and the family, legal issues and organizations.

This book is highly recommended as a handbook for adoptive families and as a reference for the adoption professional—and for the community mental health professional who may serve the adoptive family.

Elaine J. Schwartz is the Adoption Specialist, Children's Bureau, ACYF.

Briefly Noted

The Adoption Experience

Steven Nickman (New York, Julian Messner, Simon & Schuster, 192 pp., $11.00)

This short, interesting book on the experience and feelings of six adopted children with comments by the author, is directed to a young audience. Steven Nickman, a pediatrician and psychiatrist, has written this book "for the reader's enjoyment, but also to provide useful information and to give comfort to those kids who think about adoption a lot and feel angry and sad, perhaps even abandoned." The stories —which include one of young adults placing their child for adoption—are well written and, to a certain extent, have a good resolution. The book would be useful to the adoption worker to share with adopted children and prospective adoptees.

—Elaine J. Schwartz

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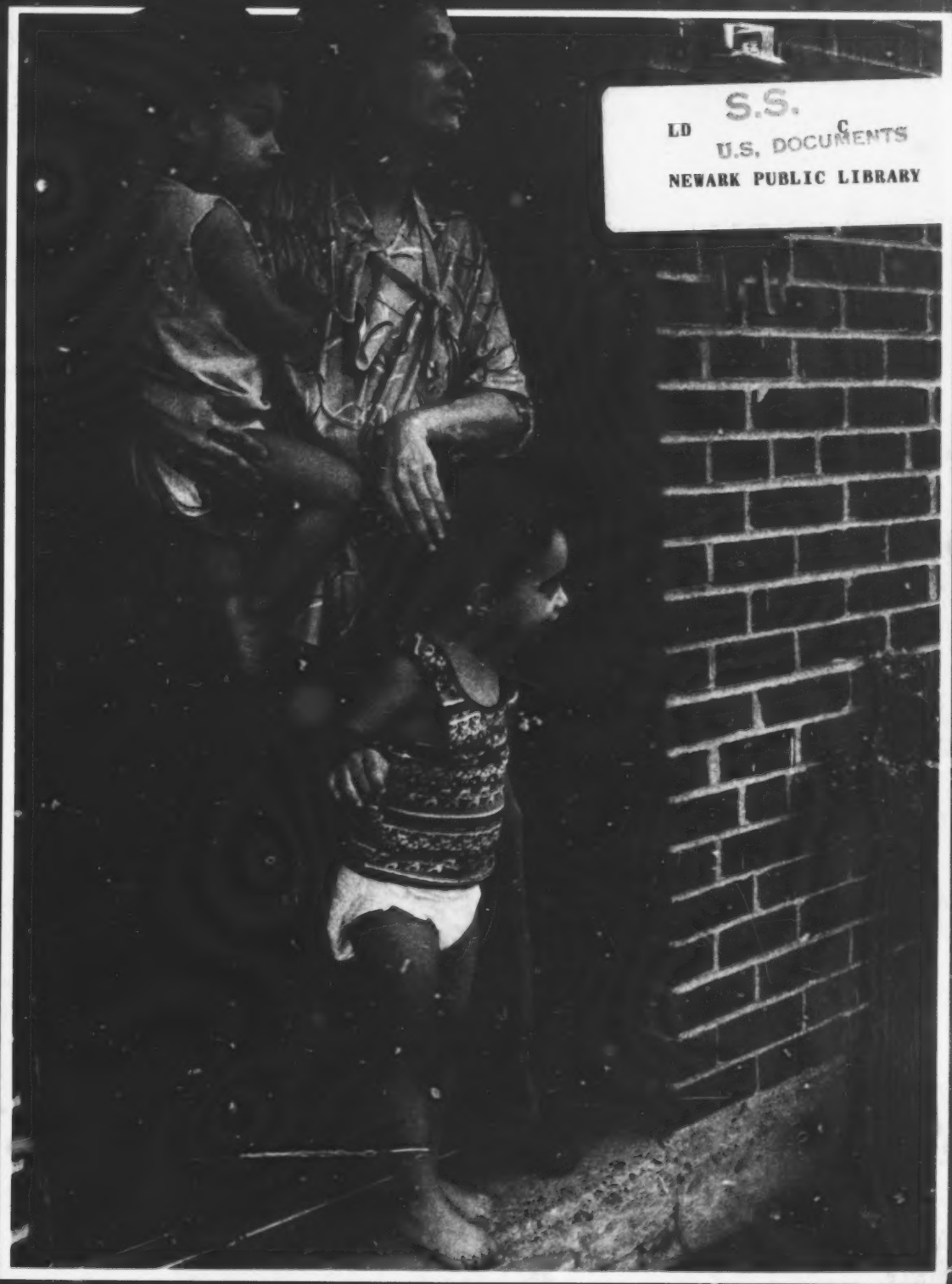
children today

November-December 1986



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pecial Issue: Family Based Services

November-December 1986
Volume 15 Number 6

children today

FYI: Students and Drugs . . . Songs About Adoption

Preventing Out-of-Home Placement of Children: The First Step to Permanency Planning by Cecelia Sudia. As this introduction to the issue emphasizes, permanency planning begins *before* placement, through the adequate provision of assistance and services to families in order to avoid any need to remove children from their homes. **4**

12

Progress Towards Change: The National Resource Center on Family Based Services by Janet R. Hutchinson. The 4-year-old Resource Center disseminates information, provides technical assistance and training and conducts research to help agencies develop alternatives to child placement. **6**

Moving Toward Family Preservation Services in Kentucky by Betty Triplett, Ishmael Preston, Ann Henry and Michele Thompson. This article examines the dramatic changes initiated to reorient Kentucky's child welfare system to a preventive model. **8**

Intensive Crisis Counseling in Florida by John H. Paschal and Linda Schwahn. Currently, 11 ICC projects are operating throughout Florida, providing immediate services to families in their own homes. **12**

SCAN: Providing Preventive Services in An Urban Setting by Toshio Tatara, Helen Morgan and Henley Portner. In Philadelphia, the Supportive Child Adult Network offers a wide range of treatment approaches to strengthen high risk families. **17**

Profiling Family Preservation Services in Utah by Jerry P. Callister, Linda Mitchell and Grant Tolley. Two Family Preservation Projects, operating in the largest service areas in Utah, are maintaining 85 percent of the most difficult-to-serve children and adolescents in their own homes. **23**

26

Reasonable Efforts to Prevent Placement and Preserve Families:

Judicial Determination of Reasonable Efforts by Debra Ratterman. An American Bar Association Study of agencies and courts is yielding information on practices that are effective in implementing the reasonable efforts requirements of P.L. 96-272. **26**

Defining Active and Reasonable Efforts by Robert J. Hunner. The project described here has resulted in guidelines to expand understanding of and compliance with both the reasonable efforts requirements of P.L. 96-272 and the Indian Child Welfare Act of 1978 (P.L. 95-608). **27**

Book Reviews: **33**

Working with Multiproblem Families

The Process of Divorce

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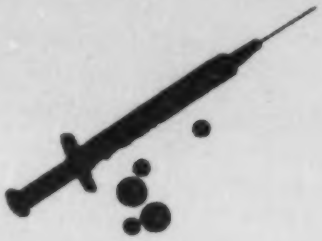
About this issue . . .

This special issue of CHILDREN TODAY focuses on a relatively new but rapidly growing area of child welfare: the provision of family based services to avoid out-of-home placement of children. This family based approach--which Children's Bureau Family Services Specialist Cecelia Sudia calls the first step to permanency planning--usually incorporates intervention, support and counseling aimed at strengthening the family unit. Services are often provided in the family's own home, at times--including evenings and weekends--most convenient to the family. In many programs services are time-limited; families are encouraged to continue, on their own, the connections with community agencies that were developed during program intervention.

Some of the most successful programs bring the resources of multidisciplinary teams and funds to bear on family problems. And most programs are highly cost effective when compared to the costs of maintaining children in foster care or residential treatment.

The articles in this issue review a variety of efforts at federal, state and local levels to implement family based programs and garner legislative support for them. We asked Cecelia Sudia to begin with an overview of the Children's Bureau's role and the impact of state efforts to meet the prevention requirements of the Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272). A frequent contributor to CHILDREN TODAY, Mrs. Sudia has long championed the idea of a special issue on family based services and gave generously of her time and knowledge to help bring the issue to fruition.

Although this is CHILDREN TODAY's first theme issue on the subject, regular readers will recall earlier articles featuring family based programs--in 1978 we were one of the first to report on the innovative Homebuilders approach (see "Homebuilders: An In-Home Crisis Intervention Program" by Jill Kinney (Jan.-Feb.). More recent articles include "Homebuilders: The Maine Experience" by Edward C. Hinckley (Sept.-Oct. 1984) and "Keeping Troubled Teens At Home" by Bonnie K. Lantz (May-June 1985). Copies of these articles are available upon request.



FYI

FYI /Reports

Students and Drugs

Nearly one-third of college students try cocaine by the time they graduate, but use of marijuana and other illegal drugs has dropped significantly since 1980, according to a study published by the National Institute on Drug Abuse (NIDA). Entitled *Drug Use Among American High School Students, College Students, and Other Young Adults: National Trends Through 1985,* the report is the ninth in an annual series highlighting data on the prevalence of drug use, trends and related attitudes of America's high school and college students and young adult population.

The findings—which span the years of 1975 through 1985—emerge from an ongoing national research and reporting program conducted by the University of Michigan's Institute for Social Research and funded by NIDA. Prepared by social psychologists Lloyd Johnston, Jerald Bachman and Patrick O'Malley of the University of Michigan's Institute for Social Research, the 237-page study is the first to release follow-up results on drug use trends after high school and is believed to be the "most extensive look at drug use on campuses."

The survey discusses such topics as grade level at first use and intensity of drug use; beliefs among students concerning various types of drug use—including perceived harmfulness of drugs and attitudes regarding legality of drug use; the social milieu of drugs; self-reported reasons for using drugs; implications for prevention; and the use of cocaine, stimulants (amphetamines), tranquilizers, barbiturates, marijuana, cigarettes and alcohol.

The researchers indicate that cocaine use remains at peak levels among high school students and young adults generally. Nearly 40 percent of all high school graduates have tried cocaine by age 27 and about 30 percent of college seniors have tried it. About one college student in every six (17 percent) used it in the year preceding the 1985 survey; one in 14 (seven percent) in the previous month —statistics virtually unchanged since 1980. Only about one-third see much risk associated with trying cocaine, a figure that has remained unchanged since 1980 despite the adverse publicity the drug has recieved.

Although it is not apparent from the statistics, disapproval of cocaine use actually remains strong among the majority of college students. Johnston reports that three out of every four students (76 percent) say they disapprove of even trying it, but an appreciable minority are willing to take the chance. "We think this is because so few see experimenting with cocaine as dangerous. In light of what is now known about the addictive potential and other medical dangers of cocaine, the levels of use are surprising and unsettling," the researchers note.

For other drugs, a different picture emerges. The proportion of college students using marijuana in the year before the survey fell from 51 percent in 1980 to 41 percent in 1984. The 1985 figure remained the same. More important, daily marijuana use dropped by more than half, from 7.2 percent in 1980 to 3.1 percent in 1985. Large decreases were also recorded in annual use of methaqualone (Quaaludes), from 7.2 percent in 1980 to 1.4 percent in 1985; of barbiturates, from 2.9 percent to 1.3 percent; and of tranquilizers, from 6.9 percent to 3.5 percent. Use of other drugs began to fall more recently: amphetamines, from a high of 21 percent in 1982 to 12 percent in 1985; and LSD, from a high of 6.3 percent in 1982 to 2.2 percent in 1985. These declines were typical for all high school graduates of the same age, not just for college students.

College students are a little less likely than their overall age group to use LSD or any prescription drugs (stimulants, sedatives, tranquilizers or narcotics other than heroin) without medical supervision. Some of the most important differences between college students and

their non-college age peers occur in the use of two legal drugs included in the study—alcohol and cigarettes. College students are more likely than their age peers not in college to report occasions of heavy drinking (five or more drinks at least once in the two weeks before the survey). Some 57 percent of male college students and 34 percent of females reported such drinking bouts, which appear to be increasing among the college men.

Cigarette smoking, on the other hand, is much lower among college students (14 percent) than among their non-college peers (31 percent). College women, however, are more likely to be smokers than are college men. In 1985 daily smoking was found among 18 percent of college women versus only 10 percent of college men, a statistic which Johnston attributes to "the tobacco industry's lavish effort to associate smoking with liberation and success."

The researchers point out that since the drug epidemic largely originated on the nation's campuses in the late 1960s, it is significant to see it recede on those same campuses. But while the overall picture has improved considerably in the past five years, Johnston calls the amount of both licit and illicit drug use among America's young age groups "striking." He concludes, "By their mid-twenties, some 75 to 80 percent of today's young adults have tried an illicit drug. The real fly in the ointment—in addition to the fact that the decline in drug use lost momentum in 1985—is that cocaine use remains at peak levels among the high school, college and young adult populations. Clearly this nation's high school students and other young adults still show a level of involvement with illicit drugs that is greater than in any other industrialized nation in the world."

Single copies of *Drug Use Among American High School Students, College Students, and Other Young Adults: National Trends Through 1985* (Publication No. ADM 86-1450) can be obtained free from the National Clearinghouse on Drug Information, National Institute on Drug Abuse, 5600 Fishers Lane, Rockville, Md. 20857.

FYI /Resources

Songs About Adoption

Adoption Adventure is the title of an audio cassette featuring a collection of nine songs that explore the feelings of all members of the adoption triad—the birth parents, the adoptive parents and the adoptee.

While a few of the selections have been previously published and recorded by well-known performers—"Little Green" by Joni Mitchell and "Mother" by Tom Paxton, for example—many have never before been published. These selections include "Always Remember," a birth mother's message to the baby she is placing for adoption; "I Will Tell Her You Love Her," written by a new adoptive mother and expressing her positive feelings toward the birth parent; and "You're My Real Mom and Dad," written for adopted children and sung by a 6-year-old adopted child.

The cost per cassette is $9.95; discounts are offered for orders of three or more. Cassettes may be obtained from the Adoptive Parents' Education Program, P.O. Box 32114, Phoenix, Ariz. 85064.

Preventing Out-of-Home

The First Step to

Permanency planning has been a major policy of the Children's Bureau since 1977. We believe that many children have benefitted from our efforts, through the states, to limit the time that they must spend in out-of-home care before they are returned to an improved family situation or placed in an adoptive home or with another alternate permanent family.

However, there is less appreciation of the fact that permanency planning begins *before* placement, through the adequate provision of assistance and services to families in order to avoid any need to remove children from their homes. While always a goal of child welfare, this provision was written into Public Law 96-272, the Adoption Assistance and Child Welfare Act of 1980. Effective October 1, 1983, judges are required to make a determination that "reasonable efforts" have been made to prevent placement or the federal government cannot participate in payment of foster care costs.

The timing and effectiveness of state efforts to meet prevention requirements have varied widely. New York, California, Iowa and Oregon were among the first states to have programs aimed at preventing out-of-home placements.

The early effectiveness of prevention, reunification and adoption programs and other improvements in the child welfare system related to P.L. 96-272 is evident in the immediate and continued reduction in the number of children in out-of-home care. Between 1977 and 1983 this number decreased from more than half a million children to approximately 262,000. However, the counter pressure of continuing increases in the numbers of children reported as physically and sexually abused or neglected, together with reductions in federal spending and shortfalls of state revenues, have led to a reversal of this trend. Figures for 1984 and 1985 reveal increases: Nearly 276,000 children were in substitute care at the beginning of 1985, indicating an urgent need for preventive services. Overall, the Children's Bureau estimates that 59 percent of the children enter care because of some form of abuse or neglect, 15 percent because of parental incompetence or absence, nine percent because of the child's own behavior, two percent because of a handicap or disability, and 16 percent for other reasons (lack of money or adequate housing, for example, or a transfer from another agency). These proportions vary quite widely by state, indicating that states have different patterns of problems to solve in order to limit placement.

Through Title IV-B and IV-E of the Social Security Act, the Children's Bureau provides fiscal incentives to states for the devel-

Cecelia Sudia is Family Services Specialist, Children's Bureau, ACYF.

Placement of Children:

Permanency Planning

by Cecelia Sudia

opment and improvement of preventive programs; Children's Bureau staff in regional HHS offices provide technical assistance and conduct joint planning sessions to encourage states to develop such programs.

At the federal level, under the Consolidated Discretionary Funds Program, New Mexico, Illinois, Delaware, Minnesota and Puerto Rico have received assistance to develop prevention programs. However, the major source of assistance at the federal level has been through the National Resource Center for Family Based Services at the University of Iowa School of Social Work. (The work of the Resource Center is discussed in the following article.) The resource materials and consultation provided by the Center, which is funded by the Children's Bureau, have reached many states and communities. In addition, many other groups have provided resources, assistance or models— particularly the Homebuilders program of Tacoma, Washington, the comprehensive family protection laws passed in New York and California and the McConnell-Clark Foundation, under the leadership of Peter Forsythe, which has funded a number of innovative programs. Moreover, the increasingly numerous state child advocacy organizations are providing information and leadership to bring the case for needed resources before state legislatures.

One measure of the success of these efforts can be seen in the 1986 *Annotated Directory of Selected Family Based Service Programs* published by the National Resource Center on Family Based Services, which describes nearly 300 family based programs, many of which are available statewide. Nevertheless, many communities still have very limited preventive services.

This issue of CHILDREN TODAY is a further attempt to assist in the development of family based programs through the provision of descriptive information. It includes articles on statewide efforts, in Florida and Utah, to increase the number of family based programs reaching difficult-to-serve children and adolescents and, in Kentucky, to reorient the entire child welfare system so that all cases are handled with a preventive focus on the family. One article, on the Philadelphia SCAN program, provides an example of a successful approach to working with that most needy of all groups: the underclass found in most metropolitan areas, whose members are often the victims of the systems established to help them.

Two other articles focus on "reasonable efforts" determinations—an American Bar Association study of courts and agencies to identify effective practices, and the work of Northwest Resource Associates to expand understanding of the active and reasonable efforts provisions of P.L. 96-272 and the Indian Child Welfare Act of 1978 (P.L. 95-608).

As these articles indicate, it takes time—at least two years—to implement a statewide program, and strong state leadership and legislative support are essential. While placement prevention programs are cost effective, start-up funding—which may come from federal grants—is very helpful.

Clearly, family focused prevention programs are gaining acceptance and support throughout the country. We strongly encourage such efforts, for the family based approach shows great promise in meeting the needs of child welfare families in a manner that is beneficial to children and cost effective for the state. ■

Progress Towards Change:

The National Resource Center on Family Based Services

by Janet R. Hutchinson

The National Resource Center on Family Based Services is funded by the Children's Bureau to assist agencies serving children, youth and families in developing family based alternatives to child placement. The center's activities, spanning a period of four years, are grouped into three divisions: information dissemination, technical assistance and training, and research. The center's eight professional staff members and 12 training consultants are based in Iowa City on the University of Iowa's Oakdale campus. From there, trainers have traveled to 35 states, training child welfare workers, juvenile probation officers and adolescent services staff in the center's unique approach to family therapy and social casework.

The center publishes the quarterly newsletter *Prevention Report* and other materials of interest to the emerging family based service field.* Exemplary programs in public and private agencies are featured in its publications, along with cost analyses, management studies and program evaluations. A new addition to the center is a computerized bulletin board, Aunt FABS, which is accessible by modem and personal computer for the cost of a long-distance phone call. Aunt FABS includes on her menu a job line with listings of family based positions open and desired, state association news, a calendar of conferences and workshops, and topical headings in the center's computerized library card file. These are a few of the services provided to help agencies adapt to a family based preventative system. Staff members have witnessed many changes over the past four years indicative of progress toward supporting families in their homes.

The Resource Center recently published the fourth annual *Annotated Directory of Selected Family-Based Service Programs.* The result of an annual survey of the more than 4,000 agencies on the center's mailing list, the directory describes 238 programs in 45 states, the District of Columbia and the Mariana Islands. By comparison, the first directory, published in 1982, listed about 20 programs; the third, 178. Many of the programs included are either units of larger, established multi-service agencies that have only recently adopted a family-focused approach or small programs that have sprung up to meet a community need for preventive services. Most are eclectic in their approach to services; that is, their developers looked at several models, chose the features they liked best and programmed accordingly. If the number of listings in the directory is any indication, the focus on families in secondary prevention programming is achieving acceptance—in rural and urban social service agencies, both public and private.

Another indication of progress is the seriousness with which leaders in the child welfare field are debating the merits of family based programming: what to call it (family-based, family-centered, family preservation); who should do it (professionals only, professional teams, professional/paraprofessional teams); direct service by the public agency or purchased from private providers); who should get it (families in crisis, multiple need families, low risk families only, high risk families only, all families); how long it should take (time-limited to several weeks or several months, variable time limits, no time limits). Programs described in the directory provide answers to all of these questions and present

points of view that should be taken seriously in the context of the community in which the program is being developed.

These signs of progress—coupled with the inception of several new state provider and practitioner associations, the scarcity of qualified workers to fill the many new positions in agencies nationwide, the increasing number of journal articles addressing family based issues, and the growing interest in incorporating family based curricula into graduate and undergraduate programs in schools of social work—indicate to the Resource Center staff that family based services are not fashion and fad but a serious, logical next step, following naturally from the incorporation of permanency planning into child welfare practice.

Family based services are not fashion and fad but a serious, logical next step.

The "thinking systems" approach, the grounding for the prevention- and family-focused movement, has had a moderating effect on developing family based policy. It is hard to explain thinking systems, and difficult to translate the concept into practice, but the results thus far achieved by programs whose staff "think systems" make the effort well worthwhile. Family systems theory acknowledges both the interdependence of family members and the interrelatedness of the family system and all the systems connected to it in a given ecological context. Clearly, the social service system itself is a major player in the public world the client's family negotiates. The job of integrating family systems theory into traditional bureaucratic structures poses some very real challenges for agency administrators and program staff.

The Resource Center is making an effort to address some of the implementation issues that arise in public agency bureaucracies. Most of the solutions we've proposed require a lot of work and a serious commitment to change; however, agency administrators with the mettle to take the plunge are generally comfortable with change and confident of their abilities to lead the organization through the process. While progress in bureaucratic change is less obvious, slower and more difficult to assess in the short range than similar changes in the private sector, the index of the center's program directory lists 62 state and county agencies that have had family based programs for a year or more, and we're aware of an equal number that are in process.

Administrators often question claims about the success of family based services, looking for proof that it really works. Proof may be forthcoming by next summer, when the results of two major research studies will be published: an 11-site summative research study of family based programs in six states and a 2-state formative research study of Homebuilders models. The former is being conducted by the research staff of the University of Iowa School of Social Work with Portland State University's Regional Research Institute as a subcontractor; the latter, by the University of Utah School of Social Work with the Behavioral Science Institute of Tacoma as a subcontractor.

A goal of the National Resource Center on Family Based Services is to see at the end of its first decade of activity strong family based programs in every state with policies that give workers the flexibility to work as intensively as needed to help families in their caseloads remain together. ■

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* Further information on materials and publications available from the Resource Center is available from the National Resource Center on Family Based Services, School of Social Work, University of Iowa, Oakdale Campus, N240 OH, Oakdale, Iowa 52319.

Moving Toward Family Preservation Services in Kentucky

by Betty Triplett, Ishmael Preston, Ann Henry and Michele Thompson

Recognizing the importance of the family system in helping families overcome their problems, The Commonwealth of Kentucky has made some rather dramatic revisions in service delivery over the past two years, making a clear commitment to a family based system that seeks to prevent out-of-home placement of children and adults.

During the past five years, children's needs increased dramatically while massive funding reductions caused children to become one of Kentucky's most neglected assets. Children felt the loss of both federal and state funds, as well as the effects of decisions made by policy makers in response to these budget cuts. From 1980 through 1984, the Kentucky Department for Social Services lost, from various funding sources, in excess of $18 million. Moreover, 141 social work positions and 152 paraprofessional positions were abolished during this time.

At the same time, the number of child abuse and neglect reports were increasing, from 15,688 in 1980 to 32,713 in 1984. The number of reported cases of sexual abuse increased from 671 to 2,126 over the same time period. The number of children in state custody in foster care increased from 2,595 in July 1981 to 2,825 in July 1984. This increase was in stark contrast to national trends, which showed a significant decrease in the number of children in foster care.

In November 1984 Governor Martha Layne Collins appointed a Protective Services Advisory Committee to review the state's protective services system and submit recommendations for improving existing services and responding to unmet needs. The committee's report, submitted in March 1985, concluded that the state must do more to prevent child abuse and neglect, and the Governor moved swiftly to address protective services issues in her call for a 1985 Extraordinary Session of the Kentucky General Assembly. The Department for Social Services prepared a proposal, which included many of the recommendations of the Advisory Committee as well as the department's initial request for additional staff to move into a family based services delivery system. The General Assembly granted the department's request and additional funding to sustain these initiatives was granted during the regular 1986 legislative session.

Even before the appointment of the Governor's Protective Services Advisory Committee, the Department for Social Services had recognized the existing problems in the system and in service delivery and had been actively exploring possible changes to shift to a preventive model to better serve Kentucky's families and children. In late spring 1985, Commissioner Anna Grace Day appointed a task force to develop a Family Based Services model for the state and to plan for implementation of the model. The task force was asked to review the literature, arrange for extensive staff training, develop or revise policies and procedures, develop new job classifications, plan for allocation of new staff, design an evaluation of the model and identify barriers and/or other tasks necessary to implement Kentucky's model.

After studying a variety of programs, the task force concluded that Kentucky could not just adopt an existing system but would need to develop one unique to the state's needs. One major determinant in this decision was the fact that, as far

as could be determined, no other state thus far had made the decision to operate a statewide family based service delivery system which used its own direct service employees almost exclusively as service providers. Contracts are also used to supplement service delivery and to provide some services that the department does not deliver.

Goals

In moving to family based services, the Department for Social Services assures that every effort is made to maintain the family as a functioning unit, to provide the maximum services to a family at the time of crisis, and to prevent the breakup of the family unit. Services in this context are intended to strengthen and maintain families and to prevent family dissolution and out-of-home placement, and the department's resources are focused on assisting families in regaining or maintaining automony while at the same time assuring protection of individuals. Specifically, the goals in using this service delivery approach are as follows:

- Strengthening and maintaining client families.
- Preventing family dissolution.
- Preventing unnecessary out-of-home placements.
- Limiting the time of out-of-home placements, when such placements prove to be necessary.
- Preventing reentry into out-of-home placements of children who have been reunited with their families.
- Reducing client dependency on social services by promoting self-sufficiency.
- Promoting adoption of children for whom intensive efforts at reunification have failed.
- Protecting children and adults from abuse/neglect.
- Preventing abuse and neglect of children and adults.

Implementation

One of the first steps taken to implement the Kentucky model was the designation of specilized staff members to relieve family services staff of several duties so that they would have more time for direct services to families. The department used some of the new staff positions created by the additional funding to establish Recruitment and Certification positions for workers to handle recruitment of adoptive and foster families, home studies, placement of children when necessary, and training of foster/adoptive parents. All of these duties had previously been the responsibility of family and foster care staff. Other positions were used to establish specialized intake teams in urban areas, which would be separate from treatment teams, and Family Services Treatment Specialist positions for each district. Anticipating a great need for training, the Division of Family Services requested and received funds to reestablish a Training Branch. A quality Assurance Branch was also established in the Office of the Commissioner with responsibility for monitoring the quality of service delivery, identifying training needs and recommending programmatic changes.

Children's needs increased dramatically while massive funding reductions caused children to become one of Kentucky's most neglected assets.

All job classifications, titles and functions were rewritten to more accurately reflect the family based services concept with the goals of increasing pay rates, implementing a career ladder and placing more emphasis on qualifications to attract a better qualified staff.

The task force has developed a model process as a framework for family based services in Kentucky. The purpose of developing the model process was to distinguish Kentucky's system from other models and to give a description of the client pathway through the social service system. All client entry will be at one point: the intake team or the designated intake worker. The model process has four exit points. Three of these deal with clients and include cases that do not require additional services; inappropriate referrals or referrals to another agency at the point of intake; and exit from the system once services are no longer needed. The fourth exit point is for foster and adoptive parents/applicants from the Recruitment and Certification Team. The four components of the model are intake services, family based services, recruitment and certification, and family treatment.

Intake is the point at which the individual or family comes into contact with the system. The functions performed in intake and the resulting assessment lay the foundation for continued interactions with a family. It serves the family's particular needs in a timely, sensitive manner, and determines the type and extent of resources required to address the family's problems. It is also the point at which the services available through the agency and the larger community

are explained to and explored with the family.

Recognizing that one person's behavior influences the behaviors of others, the *family services* component provides a full range of social services to individuals within a family context. The functions performed in this component include ongoing assessment and service planning, service provision, information and referral, counseling and case review. The family worker is responsible for services to the child in foster care and the child's family.

The *Recruitment and Certification Team* is responsible for recruiting and conducting all initial interviews, studies, group interviews, and initial and follow-up training of foster/adoptive parent applicants. In addition, teams are responsible for monitoring and supporting foster/adoptive homes and conducting annual evaluations (receiving input from family based services teams). Assistance with placement is provided to family service workers should care outside the child's home become necessary. Some teams may have additional duties such as custody or interstate evaluations and independent adoptions.

The *Family Services Treatment Specialist* (FSTS) works out of the District Office and does not carry a caseload. The specialist offers expertise to family services workers and provides support in intensive work with families. Consultation is available to staff as needed, and consultation, training and/or co-counseling is offered in cases where family based services staff feel it would be appropriate.

To structure service delivery to adequately meet the real needs of families, a case typology is being used to differentiate the type of services needed and the level of effort required to stabilize each family and prevent substitute care. The typology is a basis for a case classification that will systematize the allocation of cases among workers based on the estimated number of hours of service required to meet the family's needs.

Preventative Assistance

Many family disruptions could be avoided if funds were immediately accessible for families in crisis. In 1986 the General Assembly responded to a department request for funding by appropriating funds for a preventative assistance program for each of the next two fiscal years. This program provides emergency funds—up to $500 during any one year—to families during crisis. The goals of this service are to prevent the removal of children from the home; to facilitate the return of children to their natural parents when the major barrier to their return is financial in nature; to prevent the removal of elderly persons from their homes; and to assist those adults who are identified at risk and are in need of immediate protective service intervention. The expenditure of funds will be requested at the county level and dispersed at the district level. Utilization of these funds is being monitored and documented to show how disruption of families can be averted through early intervention as well as to document the cost effectiveness of such a program.

Training

Kentucky has made a major commitment to providing a variety of types and levels of training for supervisors and staff. Introductory training has been delivered to all family services management and supervisory staff in two 3-day segments. District orientation sessions have recently been completed, and more comprehensive, in-depth training will begin in spring 1987. The ultimate goal is to develop a competency-based training curriculum that will be available, either in its entirety or in various skill components, to meet the ongoing training needs of staff.

Problems Encountered and Attempts to Resolve Them

The leadership and management staff of the Department for Social Services are optimistic about the progress that has been made to implement family based services in Kentucky. It would be unrealistic not to acknowledge that certain problems have also been encountered. One expected problem was resistance of staff to changes proposed, especially since the changes were major and involved some organizational restructuring as well as altered roles for many staff members. Some staff members not accustomed to process implementation seemed to be waiting for that "magic start-up" date and were confused by the fact that implementation had begun in the spring of 1985 and that further implementation steps were occurring in increments. A major detriment has been the hiring restraints imposed on all state government departments during spring 1986; these restraints were, rather surprisingly, not the result of financial shortfall but the outgrowth of a cap on the number of total state employees imposed by an earlier legislative session. Fortunately, as of August 1, 1986, the department has been given permission to begin filling identified critical positions.

A number of steps have been taken to deal with these problems. Probably the most critical factor has been the commitment of the commissioner of the department and other personnel in leadership positions to this major shift in program

direction. During fall 1985, Commissioner Day and the Director of Family Services, Nancy Rawlings, visited every district in the state and met with all staff members to explain the plan for family based services. The purpose of these meetings was not only to reinforce the leadership's commitment to the family preservation efforts but also to explain structural changes that were being implemented, to outline and answer questions on changing roles and responsibilities and to specify the beneficial outcomes expected from the move toward family based services.

After these initial introductory meetings, several methods were used to keep staff advised of activities and the status of implementation plans. These included quarterly update reports on FBS, which included progress reports from the task force, summaries on the work of various subcommittees and reports from the district managers reflecting both achievements and problems encountered in each of the districts. Other communications to staff included several memoranda from the commissioner reflecting the favorable actions of the Kentucky General Assembly, which met from January through April 1986 and resulted in substantial support for the new preventive program.

A handbook for use by all staff is being developed to serve as a general guideline on the purpose of family based services, the major objectives to be achieved, the model and structure being implemented, the components involved and the roles and responsibilities of staff within the new system. The handbook will serve as an interim step to address some of the confusion and anxiety about expectations being felt and expressed by some staff.

The Family Based Services Task Force and many of its subcommittees have achieved the following: a 4-stage case review and closure process that resulted in closure of approximately 16 percent of cases statewide; the development of a public awareness/community resource development plan that included a family based services brochure and an informational package for presentation to different community groups; and design of a revised service reporting document, which will eliminate much of the duplicate work required of staff.

Following completion of the initial supervisory training, a small team (the director, the assistant director, the Management and Evaluation Branch manager and a representative of the Training Branch) began meeting in each district with the managers, district specialists and supervisors to determine what steps they were taking toward implementation of family based services and to discuss any problems they might be having. The basic purpose of these meetings was to reiterate the commitment to the family based approach, to maintain the momentum toward implementation, to applaud and reinforce the efforts that have been made and to obtain input on the content of working training.

Evaluation

The importance of building an evaluation system into a program cannot be overemphasized. An organized approach for using information to determine if services provided are having the intended effect is essential to all programs. Evaluation establishes accountability through documentation of program activities to provide information as to what the program has achieved. Program performance can be modified to achieve better results with timely information on strengths and weaknesses of the program. Results of the evaluation also provide management with needed data for future planning and budgeting decisions. The Family Based Services Task Force set up an Evaluation Subcommittee comprised of all the different levels of decision makers to ensure that information needed by each level would be gathered.

The family based services evaluation will use outcome and effort evaluation. Some of the items to be examined are reduction of abuse/neglect incidents, decrease in duration of placement, placements averted, reduction in placements compared to previous years, increased reunification, shorter duration of casework services, use of Preventative Assistance funds, length of service, number of families served, number of clients served, service intensity, caseload size, cost per case and time spent in direct contact with clients and case management.

Conclusion

Kentucky recognizes that much remains to be done and that other problems may well be encountered as we continue to move to a more preventive mode of service delivery. Still, we are confident that we are moving in the right direction and that much has already been accomplished. ■

The authors are all affiliated with the Department for Social Services, Frankfort, Ky. Betty Triplett is Assistant Director, Division of Family Services; Ishmael Preston is Manager, Management and Evaluation Branch, Division of Program Management; and Ann Henry and Michele Thompson are Family Services Program Specialists, Division of Family Services.

Intensive Crisis

At some time, nearly every frontline child protection worker is confronted with the ultimate fear: leaving a child in a home where abuse is suspected and having that child die or be severely injured. The worker is in an untenable position. If the child is not removed, the ultimate fear may be realized; if the child is removed, the family faces a series of traumatic events—and the child's long-term placement away from home may become a reality.

However, when appropriate help is available, a child does not need to be removed from home to ensure his or her safety. In Florida, that help comes from the Intensive Crisis Counseling Program.

The State of Florida's Intensive Crisis Counseling Program (ICCP) provides in-home support services specifically designed to prevent the removal of children from their homes and thus avoid their placement in emergency shelter care, foster family homes and institutional foster care. The program was modeled after Homebuilders in Tacoma,

Counseling in Florida

by John H. Paschal and Linda Schwahn

Washington, which has demonstrated success in keeping families intact.[1] Like Homebuilders, the Florida model is based on the premise that immediate and intensive intervention in the home can help keep families experiencing severe crisis together.

In 1980, the Florida Department of Health and Rehabilitative Services (HRS) proposed the establishment of two intensive crisis counseling pilot projects, one in a rural setting and one in an urban setting, based on the Homebuilders model. The services offered by the projects would differ from those provided by the department's dependency Child Protective Services programs in one very important respect: The counselors would have small caseloads in order to work intensively with families in resolving crises. The Florida legislature funded the two projects during Fiscal Year 1980-81. The department's evaluation of the pilot projects, completed in October 1982, yielded a startling finding: Of the 196 target children seen, only five had been removed by the state at the time ICCP services were terminated—a 94.7 percent success rate. The Executive Summary of the report stated:

"This evaluation has tended to confirm the cost-effectiveness of the Intensive Crisis Counseling Program model. The program's apparent ability to prevent family dissolution and avoid the much higher cost of removal and residential placement for the child indicates it may be one of the best of the department's programs."

Based on the success of the pilot projects, the state has expanded the Intensive Crisis Counseling Program. Currently, 11 projects serving about 1,100 families a year are operating statewide. All are conducted under contract with HRS.

The Florida Model

ICCP contract providers include mental health centers and social service and other counseling agencies. While ICCP is considered a mental health service, it is not considered a mental health program. Services are provided by skilled, trained counselors in a variety of settings. A program is staffed with a director who also carries a half-time caseload (two families), three counselors who each carry a maximum of four families, and a secretary. Each program serves 100 to 115 families per year and costs about $126,000 per year to operate, or roughly $1,125 per family.

When appropriate help is available, a child does not need to be removed from home to ensure his or her safety.

In order to provide immediate services to families in their own homes, ICCP counselors are on call 24 hours a day to respond to referrals, and they remain in the home for as long as necessary to facilitate resolution of the immediate crisis. After the counselors have assisted the family through the immediate crisis, they meet with family members on a regular basis (daily, weekly, etc.) for up to six weeks to teach them new skills to help prevent recurrence of crises.

A variety of therapeutic intervention techniques are used as appropriate for the family members involved. A careful assessment is made to define problems so that clients can understand them and participate in exploring and choosing their own solutions. Particular emphasis is given to skill building, especially communication and parenting skills.

Since the families referred to ICCP almost always have many problems, the counselors—who have strong backgrounds in family therapy, crisis intervention, behavior modification and other counseling techniques—assess the families' needs for other services and provide information, referral or liaison assistance toward getting the families involved with other appropriate community agencies.

Timeliness, intensity and accessibility of the service are the key factors in the success of the ICCP, as the case of Ms. Brown (not the family's real name) and her family illustrates.

Ms. Brown, 28, is the mother of two children, 9-year-old Sally and a 3-year-old son. She came to the attention of HRS when the department received a complaint alleging that Sally had been physically abused.

A medical evaluation was immediately scheduled through the child protection team, and ICCP was contacted to become involved with the family.

Initially, the mother displayed a great deal of hostility, and she yelled and screamed at her daughter while at the physician's office and at HRS. Investigation revealed that Sally's bruises were the result of her mother's physical discipline. The Browns had been referred to HRS six times in the past, primarily as a result of abuse by the girl's natural father who was no longer in the home.

ICCP counselors first identified and targeted the stresses on the family. Ms. Brown was unemployed and had [illegible]e bills. Sally was severely e[illegible]otionally handicapped and presented significant behavioral problems at school and at home, including frequent stealing episodes. Interactions between mother and daughter were negative, and Ms. Brown clearly was feeling ineffective as a parent and disciplinarian. Since she was distrustful and rather hostile at first, early sessions centered on building rapport and trust by helping her obtain immediate financial assistance to pay overdue electric bills and facil[illegible]ating communication with teachers and personnel at her daughter's school.

The ICCP therapist worked with the mother to establish a system to structure appropriate consequences for Sally's acting out behavior in the home. The therapist also coordinated a meeting at the school in an effort to improve communication between the mother and school personnel and to deal with problem behaviors in a consistent manner. A number of sessions were also spent helping the mother respond in a more positive manner to her daughter. These issues were able to be addressed partly because some concrete assistance had been provided in the initial intervention to relieve some financial stresses. When a significant level of trust had been established, Ms. Brown was encouraged to take advantage of parenting classes, which she had previously perceived as a criticism or threat.

During ICCP intervention, the family was again placed on court-ordered supervision, and the CPS worker was introduced to the Browns by the ICCP therapist prior to closure. Appropriate lines of communication were established among all professionals involved, and Ms. Brown was much more receptive to support from outside agencies. At closing and at 6-month follow-up, Sally continued to remain at home with her mother and the situation was stable.

Program Operation

The target children for ICCP services are those who have been referred to HRS for abuse, neglect or status offense behavior, primarily running away or ungovernability. The majority—about 66 percent—are referred for child abuse and/or neglect. The major criterion for participation in the program is danger of imminent removal of the child from the home. The family must live in the area served by the program and at least one family member must be willing to work toward keeping the family together. ICCP is truly a crisis intervention program—it is neither a crisis prevention nor an ongoing treatment

program, and it should not be used unless the present or potential maltreatment in the home is such that the child would have to be removed if the program's services were not available.

Families are referred to the program by child protective counselors. Referrals are made by telephone to expedite intervention and followed up in writing within 24 hours. In some instances, when the ICCP counselor cannot respond to a referral immediately, the HRS counselor may have to place the child in emergency shelter care until the ICCP counselor is available for the family.

When families are referred, the intake counselor maintains case management responsibilities until disposition, when the case is transferred to protective services supervision. The protective services supervision counselor maintains regular contact with the family and the ICCP counselor through the duration of ICCP involvement. The ICCP provider must accept referrals from the department 24 hours a day, seven days a week, but the project director determines whether or not a family will be accepted in the program. The HRS contract manager and the ICCP provider establish written procedures to ensure the full and appropriate utilization of the program, including procedures for advising HRS of the progress of cases and any extraordinary factors, and keeping HRS informed about the program's current caseloads and upcoming vacancies.

During the first two weeks, the ICCP counselor visits the family at least three times a week, and if the family has a telephone, contacts them by phone on the other days. If the family does not have a telephone, the counselor will determine whether additional visits are necessary. After the first two weeks, counselors visit families at least twice a week. Beyond these minimum requirements, the ICCP counselor determines the type and number of contacts to be made on the basis of each family's problems and service needs.

After consultation with the HRS case manager, the counselor refers families in need of additional supportive services to appropriate community resources and advises agencies of the HRS case manager's overall responsibility for the case. The counselor maintains weekly contact with the case manager and immediately notifies him or her of any extraordinary factors, such as suspected abuse or neglect, a serious illness of a family member or a child's running away from home.

If it becomes necessary for the case manager to remove a child from a home, the counselor continues to be involved with the case until the child is actually removed, as long as the time period does not exceed six weeks. The decision for removal rests with the HRS case manager.

Cases are closed when the ICCP counselor determines that the family has received maximum benefit from the program's intervention services. However, no case can remain active for longer than six weeks. An exception may be made if the case manager, the contract manager and the ICCP counselor agree that continued services are necessary for a limited time. Case closure is discussed between the counselor and case manager at least a week prior to termination of services to the family and, upon termination of the case, the counselor submits a written termination summary to the HRS case manager.

Families Served and Outcomes

Since 1981, each ICCP project has served between 110 and 120 families per year, about half of them headed by single parents. The mean age of the target child was 12.5 years. More than 66 percent of the family heads were employed, and yearly family incomes ranged from less than $7,500 (39.1 percent) to more than $20,000 (13.1 percent), with a mean of $10,500. By race, 61 percent were white, 29 percent black and the remainder, Hispanic.

Since the program's inception, approximately 4,200 families have received ICCP services. Ninety-five percent of the families were intact when program services were terminated, and 83.8 percent of the families served in the seven earliest projects were still together 12 months after receiving program intervention.

Conclusion

Since no controlled experiment has been conducted to ascertain a relationship between ICCP services and the avoidance of out-of-home placement, we are not able to make a definitive statement. However, we do believe that the ICCP program has had a significant impact in helping Florida achieve and continue reductions in foster care placements. For the 5-year period prior to implementation of ICCP (1976-80), the average monthly number of children in foster care was 7,923 and the average rate of children in care (per 1,000 children under the age of 18) was 3.3. For the 5-year expansion period (1981-85), the average number of children in foster care was 6,401 and the average rate was 3.1. Between April 1984 and March 1985, when ICCP began operating statewide, the placement rate dropped to 1.4 (3,499 children), and the average rate of children in foster care declined to 2.6. For this same period, Florida experienced a 12 percent increase in children referred for abuse or neglect and a 50 percent increase in the number of children involved in indicated child abuse or neglect referrals.

Table I.

Foster Care Rates: Eight Largest States

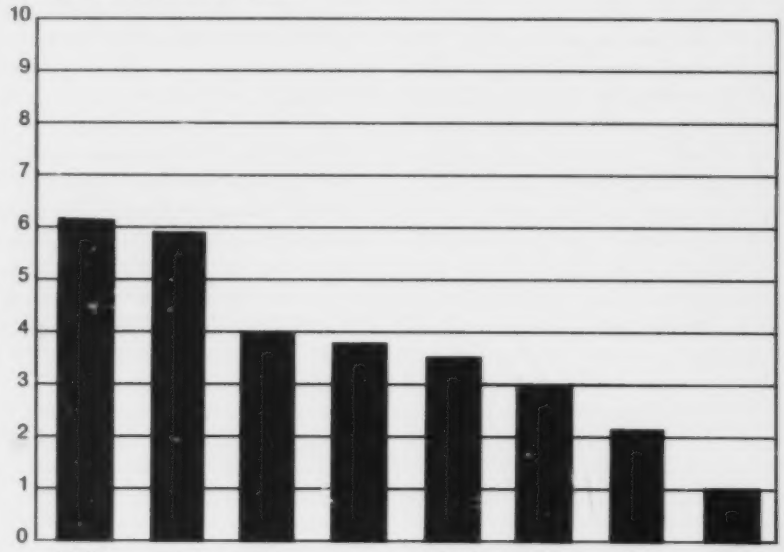
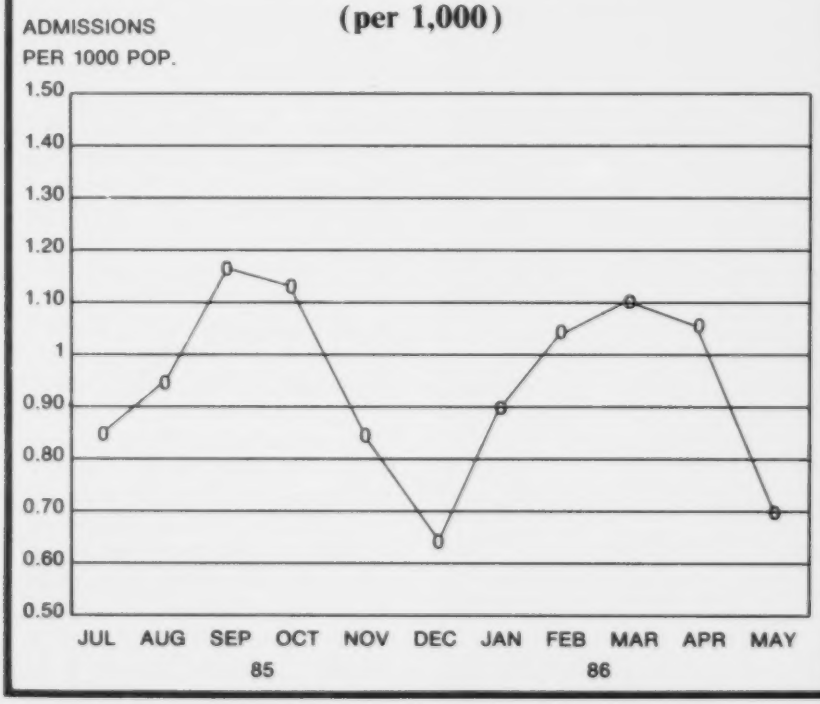


Table II.

Children in Foster Care

(per 1,000)



A recent analysis of national foster care data conducted by the Children's Bureau, ACYF, indicates that Florida has one of the lowest foster care utilization rates in the nation.[2] Using state foster care data from five to six years ago, the analysis established a rate for each state based on the number of children in foster care on a single day and the total number of children in the state. Nationally, only eight states nave a lower placement rate per 1,000 children under 21 years of age (see Table I). Our current objective is to reduce the rate of out-of-home placement even further—from the 1.4 per 1,000 level in March 1985 to no more than 1.1 children per 1,000. As Table II indicates, we are making progress in achieving that goal.

The Intensive Crisis Counseling Program has received strong support from both HRS and the state legislature. Since 1981, with the exception of one year, the state has provided funds every year to expand the program, and we are looking forward to establishing ICCP projects in additional sites. Our client population has expanded as well, as more families with children with severe emotional problems are being referred. We are also looking forward to extending ICCP services to this most difficult-to-serve population. ■

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[1] See "Homebuilders: An In-Home Crisis Intervention Program" by Jill Kinney, CHILDREN TODAY, Jan.-Feb. 1978.

[2] *Child Welfare Statistical Fact Book, 1984*, McLean, Va., Maximus, Inc., 1986.

SCAN:

Providing Preventive Services In An Urban Setting

by Toshio Tatara, Helen Morgan and Henley Portner

Photos by Donnie Roberts

About 90 percent of families who receive services are headed by single parents.

In the early 1970s, Peter Wilson, M.D., a pediatrician in Philadelphia, and other professionals from area hospitals found that they shared a concern for preventing and treating child abuse and neglect. By 1975, this shared concern had evolved into a standing multidisciplinary team for suspected child abuse and neglect which was, at that time, based at the Philadelphia General Hospital. Today, the Supportive Child Adult Network (SCAN) has become one of the largest not-for-profit organizations in Philadelphia specializing in a multidisciplinary, family-centered approach to the prevention of child abuse and neglect.

The characteristics of the SCAN program and of the families at risk who receive program services are representative of many substitute care placement prevention efforts in urban settings. For this reason, the American Public Welfare Association (APWA), under a contract from the National Resource Center on Family Based Services and as part of its effort to help to strengthen substitute care placement prevention programs, chose to document SCAN's program. The purpose of the documentation was to provide child welfare managers with information about the operation of a well-established prevention pro-

gram in an urban setting; this article describing SCAN's program is based on that documentation.

Target Population

SCAN serves at risk families with a history of child abuse and neglect and who live in the city of Philadelphia. Of the approximately 500 families who receive SCAN's services each year, staff members estimate that about 90 percent are headed by single parents and that 50 percent of the parents were 18 years old or younger when their first child was born. Ninety-five percent of the families receive AFDC or SSI; 85 percent are black. On average, the families have three or four children, and approximately 60 percent include an infant. Frequently the children in these families have special health care needs which are not being met. Some of the children present overwhelming physical handicaps, are overly demanding or have difficulties in school.

Many of the families live in substandard apartments or public housing projects that are overcrowded, unsanitary and often have neither heat nor other utilities. Many lack adequate food. The situations are exacerbated by the clinical conditions of the parents: SCAN staff estimate that almost 50 percent of the parents suffer significant depression; 50 percent have alcohol or drug related problems; and 25 percent function at a low intellectual level. Some of the parents have never learned to love or are unaware of children's needs and the stages of child development; some are unable to accept the total dependency of a young child. In these circumstances, in which there is a stressed parent, a needy child and, in particular, if there is a perceived crisis, child abuse or neglect can occur.

SCAN's Philosophy

SCAN services are designed to help strengthen the functioning of at risk families and prevent the separation of children from parents. In its attempts to interrupt the intergenerational cycle of child abuse and neglect, SCAN provides a program that is founded in firm belief in the importance of family based services and in dedication to providing high quality service for a population of disadvantaged children and their parents. SCAN further believes that child abuse and neglect are both family and social problems and that a wide range of treatment approaches—social, medical, environmental, psychological and educational—is required to promote the welfare of each child and each family served. Reflecting this philosophy, the objectives of SCAN's program are to:

- monitor, strengthen and treat high risk families in order to protect children from serious injuries and problems;
- facilitate the healthy growth and development of children at risk;
- reduce those psychosocial and environmental stresses that can lead to child abuse and neglect;
- prevent the separation of children from parents whenever possible;
- treat those health conditions that are the result of child abuse or neglect; and
- educate, inform and provide technical assistance to professionals and community members about the problem of child abuse and neglect.

These objectives are achieved through SCAN's multidisciplinary approach to services, an approach that combines social work, outreach nursing and psychological services with medical consultation. Services are provided by SCAN's staff of trained social workers, nurses, pediatricians, nutritionists and psychologists.

The social work services include both protective casework and family counseling as well as the teaching of everyday living skills. Home nursing care and the teaching of nutrition, child care and child development are included in nursing services. SCAN's psychological services include evaluation, referral and support for families needing mental health services. The medical consultation services provide both health supervision and outpatient pediatric care at SCAN's weekly clinic at the University of Pennsylvania Children's Hospital.

Organizational Structure

In June 1977, following the successful conclusion of a federally funded demonstration project, SCAN was incorporated as a not-for-profit organization—an event that coincided with the city's closing of the Philadelphia General Hospi-

tal. Although SCAN now receives all of its referrals from the Philadelphia City Child and Youth Agency (PCCYA), it does maintain an administrative and professional connection with the University of Pennsylvania Children's Hospital and the Philadelphia Child Guidance Clinic.

SCAN is governed by an 11-member board of directors which includes not only child welfare advocates but also professionals who represent areas of expertise needed for sound program administration (for example, personnel manager, certified public accountant, lawyer and grant manager). Dr. Wilson, appointed by the board, has been the program director during the entire life of SCAN and has provided continuity as the program has evolved.

Initially, SCAN relied mainly on paraprofessionals to provide services. These paraprofessionals lived in the area and were trained and supervised by a staff of nurses, social workers and psychologists. However, the number of professionals has gradually increased as SCAN desired to be more effective in dealing with the complex problems of the families served. Today, SCAN has a 39-member staff and employs largely masters-level social workers, bachelors-level caseworkers and nurses who provide direct, professional services to the families referred by PCCYA.

SCAN's revenue sources are the city of Philadelphia, contributions, limited interest income, educational events, grants and fees and honoraria from staff speaking engagements. No fees are charged to the families who receive services. The city of Philadelphia reimburses SCAN for its services at a daily rate which varies with the level and types of services which it has provided.

SCAN's nursing unit brings a special health care dimension to program services.

Program Operation

The cases referred to SCAN are generally those for whom the Children and Youth Agency has determined either that the abuse or neglect report was indicated and involuntary protective services are required, or that the family is at risk and voluntary services to children in their own home are desired. SCAN staff have found that they are more successful with, and prefer to serve, certain types of families. These include families in which child abuse and/or neglect has occurred or is at high risk of occurring, and especially those families with young children; families with a combination of problems (inability to cope with parenting, teenage parenthood, no family and/or neighborhood supports, unmet emotional needs, poor education) in addition to the problem of child abuse and/or neglect; and families in which the children are unwanted by the parent, physically or mentally handicapped, overactive, difficult to manage, born prematurely or suffer from a demanding medical problem.

SCAN usually does not accept families without a child or a responsible adult or emancipated minor who is caring for children. The program also generally does not accept families in which immediate child placement is necessary or in which the parents are severely mentally ill or have chronic alcohol or drug problems and are unmotivated to seek treatment. Families for whom only mental health treatment or only parent education or support are recommended are also referred elsewhere.

The average daily caseload is 250 cases. Of these, about 40 percent are voluntary. SCAN works intensively with each family (a minimum of two to four hours a week) over at least a period of several months. Although a small percentage of cases are closed after a

short period, the majority receive services for nine to 15 months. Placement occurs in about 10 percent of the cases, but even when placement occurs, SCAN staff members believe that their services have delayed the removal of the children and will shorten their time in substitute care until reunification is possible.

Intake

Highly trained staff are assigned to intake to assure that appropriate cases are selected and to prepare client families to use services effectively.

The initial visit, which takes place in the family's home, always includes the SCAN intake worker and the Child and Youth Agency direct service worker, who leads the family's transition to the SCAN program. The purpose of this initial intake interview is a joint assessment of the family's problems by the SCAN worker, the PCCYA worker and the family. Often this assessment reveals, in addition to the presenting problems, others that cannot be ignored—inadequate housing, alcohol abuse, poor nutrition and so forth.

Depending on the circumstances of the case, SCAN intake may also include, in addition to the intake worker, the nursing coordinator, the psychologist and, occasionally, the pediatrician. Generally, each month six to 10 referrals involve medical problems and about five to eight referrals indicate use of the psychologist to assess mental health problems. Because the number of referrals of cases with disturbed family members has risen, the psychologist's involvement has also increased.

Following the initial visit, the comprehensive intake assessment takes an average of 10 to 15 days. During this time, SCAN gathers the medical, psychological, psychiatric, educational and social data that

Children's health is also monitored at weekly clinics at Children's Hospital.

may be required to supplement the assessment. If indicated, SCAN may convene a multidisciplinary team or arrange for a case conference, psychometric testing or psychiatric evaluation. Staff members also sometimes make use of the evaluation resources of the Philadelphia Child Guidance Clinic, Children's Hospital and the Hospital of the University of Pennsylvania.

SCAN also attempts in all cases to involve the client in the development of the case plan. Even in involuntary cases, the families are invited to participate in deciding how the service requirements will be met. For example, medical appointments must be kept, but the client may participate in setting the time and in choosing the health care facility.

The intake and assessment period concludes with the development of the intake study and the Family Service Description. The intake study provides operational definitions of the client's problems, a history of the problems, possible solutions, the impressions of the intake worker and the consultants, and the prognosis of the case. The Family Service Description is developed with the family and outlines the problems that exist, the actions to be taken, the provider and the time frame. It is signed by both the parent and the SCAN worker.

Service Provision

Following intake, the case is assigned to a direct service worker. On average, outreach workers carry 12 cases and unit directors carry four. The outreach nurses carry cases involving families with serious medical problems, including medically compromised infants and children.

SCAN services are characterized by extensive outreach efforts to families to reduce resistance to service and establish and maintain trust, and by an emphasis on task-focused counseling with behaviorally defined and measurable goals and outcomes. Other program characteristics include training, direction and coaching in life skills (including homemaking, budgeting, meal planning and educational and vocational planning), parenting skills (such as alternatives to corporal punishment, understanding child growth and development and effective parent/child communication) and skills to enhance family health.

Program services are also characterized by a thorough use of community resources to support and improve family functioning, health counseling and monitoring at home as well as at the weekly clinic at Children's Hospital, and skilled "risk monitoring" through careful attention to indicators of high risk for abuse or to actual abuse of family members. Another important program characteristic is the ability of SCAN direct service staff to collaborate with collateral resources to implement service interventions.

A special aspect of SCAN's approach is that the staff members share everyday tasks with clients. SCAN believes that the multifaceted problem of child maltreatment requires both concrete services and the active involvement of all staff to bring about successful family change. Thus, staff members view the "practical" and "action-oriented" aspects of the program to be critical to the service they provide. In particular, sharing activities with families is seen as an important vehicle for reaching resistant or low-functioning clients whose willingness or capacity for verbal interaction is limited. The provision of concrete services is seen as an opportunity to observe the parent's judgment and child management, to monitor indicators of stress and the risk for violence, to provide a model of appropriate behavior, and to demonstrate support for the parent's efforts.

Examples of this approach would include an outreach nurse who might teach a young mother how to feed her failure-to-thrive infant and who might then "share" this activity with the mother two or three times a week in order to coach and direct the feeding. Similarly, a SCAN social worker might accompany a parent on a shopping trip in order to coach the parent in managing the children's behavior without threats or harsh treatment and to model careful shopping techniques by checking prices and using coupons. Or, a family worker might accompany a parent to the pediatric clinic to explain clinic procedures and demonstrate effective ways of interacting with the hospital staff.

One of SCAN's unusual features is the nursing unit, which is supervised by the nursing coordinator. The nursing coordinator acts as an information resource for medical questions—she may, for example, assess, with the family worker, an infant's caloric intake and growth in order to determine the risk of failure to thrive. The four outreach nurses both carry cases and work as team members with the family workers and social workers. Among its most important tasks, the unit gathers health and immunization information from the various health care providers that a family may have used and makes health care referrals. This information becomes a part of the continuing assessment of a child's growth and development.

The nurses also counsel parents about childhood illnesses that may require a doctor. The unit is particularly important in situations involving medically compromised and premature infants. In these cases, the outreach nurses instruct and coach parents on the use of medical equipment, ensure that medical appointments are kept and monitor the child's growth and development. Overall, the unit adds a special health care dimension to program services, one that is of particular importance to families

that have not previously had adequate health care.

Staff members work both individually and in teams to provide services. Client needs dictate the team composition—a team may consist of a social worker and a family worker, or a nurse and a family worker or social worker. SCAN believes that a team approach not only improves the quality of service but is also an efficient use of skilled staff.

The psychologist is available to assist in assessing cases. For example, the psychologist might consult with workers to review clients' mental health histories and assess their capacities. The psychologist also conducts some 15 evaluations a year and shares the results with workers and clients. Those parents who need therapy are then referred to a mental health facility. Occasionally, the psychologist is called on, as an expert witness, to testify about the evaluation results and parents' ability to care for their children.

Coordination with Community Agencies

Since an important component of SCAN services is training in life skills, workers are often involved when clients need the services of community agencies. By accompanying clients and acting as advocates, workers facilitate the client's use of such resources as public assistance and subsidized housing. Frequently, workers assist clients in making appropriate use of mental health and family planning services and public health clinics. They also assist in ensuring that there is early educational intervention when a child is identified as developmentally delayed, in requesting nutritional supplements for young mothers and their infants from WIC, and in helping clients search for emergency housing. They make referrals to the archdiocese and other resources for emergency food, and they also link clients with community legal services when needed.

By sharing everyday tasks, like grocery shopping, with clients, SCAN workers model appropriate behavior and demonstrate support for parents' efforts.

In hazardous family situations, SCAN assists the Child and Youth Agency in documenting the risk and gathering information and helps in pooling the information so that one work plan may be developed for all agencies involved with the family. On occasion, SCAN cooperates with police investigations of such situations and is often called on by both criminal and family courts for testimony.

Case Closure and Follow-Up

Although SCAN recommends case closure to the Philadelphia City Child and Youth agency, the final decision rests with PCCYA. However, the SCAN worker prepares the family for the termination of the worker's involvement.

Many SCAN families, who might otherwise be unwilling to seek health care, continue to be seen at the weekly clinic at Children's Hospital. Some families also continue to telephone program workers for advice. If the SCAN worker decides that a family again requires services, the case is referred to PCCYA to be reopened.

Conclusion

Although family preservation is the primary goal of SCAN's program, staff members believe that program success must be measured by more than the number of families avoiding placement. When no serious abuse has occurred in active cases, when malnutrition has been eliminated, when immunizations are completed, when educational needs are met, when developmentally delayed preschoolers receive early intervention services, when teenage mothers are functioning on their own with their children—when these are accomplished, SCAN feels that its program has been successful. By combining careful intake, a multidisciplinary team approach, task-oriented counseling, medical services and monitoring, SCAN has developed a family based prevention program that produces these results for high risk families in an urban area. ■

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Profiling Family Preservation Efforts in Utah

by Jerry P. Callister, Linda Mitchell and Grant Tolley

In 1978, there were 1,289 children in foster care in Utah on any given day; in 1985, this number had declined to 950 children.

The Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) has had a crucial impact on how child welfare workers in Utah view troubled families. Planning for children has been promoted aggressively throughout the state and has significantly influenced the attitude of staff toward maintaining children in their own homes or finding more appropriate permanent placements outside the home.

In 1985, the Department of Social Services funded Family Preservation Projects in Weber County and West Salt Lake County, two of the largest service areas in Utah. The decision to fund the projects was based on the belief that children and adolescents should remain with their families whenever possible, and on the expectation that foster care expenditures might be reduced.

Utah's policies toward strengthening families and preventing out-of-home care where appropriate are similar to those of other programs throughout the country. The project's philosophy stresses the following principles:

- Society should be willing to invest as much in a child's own family to prevent placement as it pays for out-of-home care.
- The family is the most powerful and primary social welfare institution and cannot be replaced.
- Parents are in charge of their families; Family Preservation staff are there to assist them in this role.
- Services, for the most part, should be provided in the home.
- Staff should be available to assigned families 24 hours a day, seven days a week, for up to 90 days, to help the family remain together.

The project's primary objectives are to prevent the unnecessary removal of children and youth who are in imminent danger of an out-of-home placement, and to empower the family with more effective coping skills and awareness of community family support resources. It became obvious from the start that to be successful, Family Preservation staff would have to focus on only one or two critical objectives in their work with the family.

Intervention Strategies

Normally, goals and priorities are negotiated with the family during the first week of intervention. Because Family Preservation staff believe that family members are the experts regarding what needs to be accomplished for the family to remain intact, they are encouraged to determine their own priorities for intervention. In cases where there is a history of violence, suicide, ungovernability or delinquency and the worker must define priorities, differences in agendas are discussed and negotiated in an open, nonjudgmental manner.

Since intervention is aimed at behavioral change, the focus is on an increase in positive, desired behaviors that help reduce negativism, generalities or poorly defined expectations. A thorough assessment

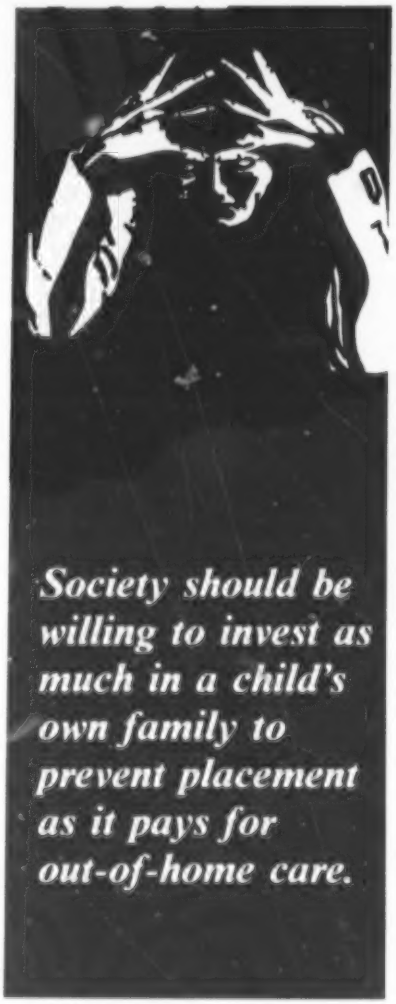
is made to determine precipitating or reinforcing factors associated with current behaviors and interaction patterns. Solutions, options and alternatives are then explored with the family and adapted to its unique strengths, level of functioning, values and energy level.

Intervention strategies are continually monitored and modified until solutions feel comfortable and result in desired behavior changes. Family Preservation workers are encouraged to remain creative and flexible and to offer the family hope that it can change and remain intact. This is best accomplished by dividing goals into smaller achievable steps so the family can experience success early in the intervention process.

Actual intervention usually involves teaching families such new skills as parenting, time and financial management, housekeeping, conflict resolution, communication, assertiveness, negotiation, impulse control and decision making. Additionally, there is an attempt to teach the family to use natural support systems or community resources.

The project's work with the Stevens family illustrates these strategies.

The Stevens family was referred to Family Preservation Services by the probation officer of two boys within this family of eight children. Donald, 13, and Mark, 11, were both on probation for shoplifting, theft and vandalism. In addition, both boys consistently missed school, refused to comply with their parents' requests at home and were classified by their probation officer as "ungovernable." Mark had not attended school for over a month; he had threatened suicide, was increasingly violent to family members, isolated himself in his room and slept a great deal. A psychologist from a local mental health agency evaluated Mark and recommended out-of-home placement in a hospital inpatient psychiatry unit to treat his depression and provide needed structure.



Society should be willing to invest as much in a child's own family to prevent placement as it pays for out-of-home care.

Agencies involved with the family had judged it chaotic and had expressed little hope for change. The family was plagued by such problems as inadequate income (less than $12,000 annually) and a fire that burned their home and furnishings two years ago. The father —who had been a machinist but was unable to work because of a heart condition—had been physically abusive to his sons on a number of occasions. Because of disagreements about discipline, hostility toward authority and the father's lack of intellectual competence, the parents were judged as uncooperative in setting limits for their children.

The family worker assigned to the case determined that what the parents most wanted was to improve the boys' school attendance and gain more cooperation from their children. Much of the marital discord stemmed from disagreements on how to achieve these goals. The worker also identified improving the family's financial situation and obtaining household furnishings as important parental goals. All eight children requested more involvement with their family through such activities as playing games, taking vacations, going places individually with their parents and having "more fun." Less yelling and hitting and fewer arguments were also mentioned as desirable by the children, and Donald and Mark stressed "not being hassled" by school personnel as goals.

Intervention with the family focused on teaching skills that would enable them to accomplish these goals. Specifically, this involved increasing parenting skills and the parents' ability to manage anger and resolve conflicts, improving the children's school performance and attendance, and increasing the children's compliance with household rules. The family and worker selected these four goals after discussion centering on a 17-item "goal list." Focusing on concrete needs, such as the one for household furnishings, was emphasized both to improve the family's environment and to create a trusting relationship between the worker and family, who had been distrustful of previous helping efforts.

Although all family members were involved in the family's problems, most skills building was directed to the parents, who are viewed as key elements in maintaining the changes that evolve during intervention and in teaching and influencing their children as family needs change and the children enter new stages of development.

A serious behavioral pattern in

the Stevens family that had many variations on the same theme had brought the family to the community's attention on several occasions. The sequence of events usually unfolded with an action by Donald or Mark that Mr. Stevens considered a deliberate provocation. Mr. Stevens reacted to this by threatening or blaming his son, who would then challenge his father, destroy household property, act out his aggression toward siblings or run from the house. Mr. Stevens would then become enraged and attempt to punish or restrain the boy.

When other family members attempted to intervene, the conflict usually escalated. Mrs. Stevens' attempts to stop her husband's aggressiveness often triggered an argument between t' e parents that eventually involved the children taking sides with either parent or child in the ensuing verbal or physical melee. Because of this behavioral pattern, there was little structure, effective teaching or limit setting in the family. The parents had withdrawn from their limit-setting roles and had discontinued positive family activities because of the risk of conflict. As a result, acting out by the boys was increasing.

Skills taught to the family were gleaned from a "clinical services list" and a "concrete service list" designed to aid the therapist in choosing intervention techniques that are then tailored to "fit" the family. Concepts featured in the STEP (Systematic Training for Effective Parenting) manual proved particularly useful in enhancing parenting skills and helped Mr. Stevens influence his children without resorting to conflict, threat or force. Mrs. Stevens was able to use the principles and rationale of "democratic" parenting to discipline her children with less guilt and to avoid protecting them from consequences that would aid in their learning.

To resolve conflict, the project worker taught family members negotiation skills through the use of a game and role playing. Emotion control skills that demonstrated the concepts of Rational Emotive Therapy (RET) developed by Albert Ellis helped both parents and children manage their anger and depression. The worker also developed a "crisis card" to help Mark and his parents identify events that sparked crisis situations and to avoid escalation of conflicts before they were out of control.

Principles of positive and negative reinforcements and a chart to monitor progress improved the children's motivation to attend school and promoted compliance with household rules. After the collection of baseline information, reinforcements were made contingent on the performance of target behaviors, including school attendance, chores and compliance with household requests and rules. The rules had been negotiated with the children's input. The family was encouraged to plan a number of activities during the intervention period to strengthen the relationship between the parents and children and build cooperation among family members. Donald and Mark learned social skills through role playing such situations as making requests instead of demands, accepting criticism and taking no for an answer.

One objective during intervention is to establish supportive linkages to the community. The school created a reinforcement system and made reports home, and the teacher received feedback on effective methods of motivating Mark and setting limits for him without getting trapped in escalating power struggles. The juvenile court became involved in the Stevens case after a hearing was requested and Donald and Mark were found in contempt of violating a court order to attend school and maintain curfew. Both boys were sentenced to 10 days in detention, but the penalty was stayed based on their appropriate behavior at home and their compliance with curfew. The detention order was used on a number of occasions when the boys' behavior seemed out of control, and brief stays in the detention facility that were carried out with the parents' consent seemed to be effective in motivating the boys to comply with limits at home. The probation department helped to reinforce desirable behavior by offering activities to the boys when they acted appropriately at home. With their worker, Mr. and Mrs. Stevens attended meetings of community agencies to gain experience in community participation and the use of community resources to cope with their marital and family problems.

A number of concrete services—transportation, furniture, clothing and food stamps—were provided for the Stevens family. A local service sorority also donated food, toys and gifts for the Thanksgiving and Christmas holidays. Homemaking services were considered but not required because the children began doing more chores around the house. As family conditions and their coping abilities improved, the parents' depression lifted and they were able to invest more energy in maintaining their home. During the intervention period Mr. Stevens found a job, which helped to alleviate the family's financial stress.

Results of intervention work with the Stevens family show substantial levels of improvement in family functioning. Following the intervention period, ongoing counseling on a regular basis using community mental health agencies is often recommended so that the family can achieve desired goals. In many cases, however, follow-up therapy is not sought because the family has achieved a stable level of functioning and needs a chance to apply

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Reasonable Efforts and Preserve

Editor's note: In 1985, the Children's Bureau funded four projects to provide resources and technical assistance to judges and the courts around the determination that "reasonable efforts" have or have not been made to prevent the need for placement. Results of two of the projects are described in the following articles. The two other projects are being conducted by the University of Tennessee ("Defining Reasonable Efforts: A Project to Unify Judicial and Agency Approaches") and the National Council of Juvenile and Family Court Judges ("Placement Prevention Training").

Judicial Determination of Reasonable Efforts

by Debra Ratterman

Among the most important trends in current child welfare practice is the emphasis on improving services to enable children to remain in their own homes rather than being placed in foster care. This emphasis is reinforced by the "reasonable efforts" requirements of the federal Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272). The Act requires that child welfare agencies provide services to prevent unnecessary placement and that, in each case, a court must determine that the state agency has made reasonable efforts to prevent or eliminate the need for placement.

The Foster Care Project, a part of the American Bar Association's National Legal Resource Center for Child Advocacy and Protection, began a special study on state implementation of "reasonable efforts" one year ago under a grant from the Children's Bureau. The purpose of the project is to develop guidelines to help child welfare agencies and courts understand reasonable efforts requirements and to prevent the unnecessary placement of children.

The study was completed in July, and we are just beginning to analyze the information collected. This article will review some of the preliminary findings and recommendations for agencies and courts.

A Study of "Best Practices"

The study was conducted by an attorney/social worker team consisting of Project Director Mark Hardin and myself—an attorney—of the Foster Care Project, Professor Theodore J. Stein of the

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to Prevent Placement Families

Defining Active and Reasonable Efforts To Preserve Families

by Robert J. Hunner

Combined with other significant changes, two federal laws—the active efforts provisions of the Indian Child Welfare Act of 1978 (P.L. 95-608) and the reasonable efforts provisions of the Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272)—are changing the face of foster care and child welfare services in the United States. In order to expand understanding of these "efforts" provisions, Northwest Resource Associates in Seattle, Washington, was awarded a grant from the Children's Bureau and the Administration for Native Americans, OHDS, to develop a guide that would describe delivery of services related to these emerging elements of child welfare services.

The Indian Child Welfare Act of 1978 was designed "to protect the best interests of Indian children and to promote the stability and security of Indian Tribes and families." Child welfare workers are required to make active efforts to provide remedial services and rehabilitative programs designed to prevent the breakup of Indian families. The

Adoption Assistance and Child Welfare Act of 1980 requires that reasonable efforts be made to prevent or eliminate the need for placement.

Some distinctions between the two acts should be pointed out.

Under the provisions of the Indian Child Welfare Act, the court must be satisfied that active efforts have been made to provide remedial services and rehabilitative programs and that these efforts have proven unsuccessful. Without the finding of active efforts, a child may not be removed. Under P.L. 96-272, the court must be satisfied that reasonable efforts were made to prevent removal of a child or to reunify children already separated from their families. Unless the court has determined that these reasonable efforts were made, states and Indian tribes may not claim federal funding for the placement of those children who are otherwise eligible for federal financial participation. Compliance with this provision is monitored by federal auditing and a program review process.

This is not the case with the Indian Child Welfare Act. There is no federal auditing or program review to ensure that the active efforts provisions are being appropriately implemented, and there are no financial considerations that apply to compliance.

These "efforts" provisions—while instituted in the laws of many states and included in established policies and procedures under which child welfare workers operate—have been applied differently in different jurisdictions. Undoubtedly, this reflects the need to distinguish between the words "active" and "reasonable": That is, given that the different words were used, it would seem that different levels, kinds or intensities of effort were expected.

As Northwest Resource Associates grappled with these distinctions in developing the guide, we eventually agreed that for implementation purposes, in order for an effort to be a reasonable one, it must be active. It is possible that an effort could be active without being reasonable, such as in a situation of inappropriate or ineffective case planning and referrals. Active efforts, therefore, must also be reasonable.

While the two concepts may seem simple and direct, they involve complex combinations of investigative and assessment skills, professional judgment, effective case planning, the availability of appropriate service resources and sensitivity to the ethnic and cultural background of the child and family.

One way to understand the efforts concepts is to examine their intents: to protect children from abuse and neglect; to promote the provision of services that support families; to preserve families; and to reinforce cultural identities. Both Acts imply that foster care should be reserved for those children for whom no other alternative will provide the necessary protection. Thus, the efforts provisions obligate those who intervene in families to do so only when necessary; to reach their decisions about families and risks to children only after careful assessment and evaluation; to use the least intrusive, family-strengthening and supportive services that will reduce or eliminate risks to children; and, whenever possible, to provide this support and these services at the appropriate point in time and with the intensity necessary to eliminate the need for out-of-home placements of children.

Assessment and evaluation of the family situation is essential to satisfy the reasonable and active efforts requirements. Unless the family assessment has been thorough and accurate, no subsequent efforts can be considered either active or reasonable.

Active and Reasonable Efforts to Preserve Families: A Guide

A Guide for Delivering Services in Compliance with the Indian Child Welfare Act of 1978 (P.L. 95-608) and the Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) discusses the following nine major service areas, indicating which services are most appropriate, and in what order, for various child welfare cases: Alcohol and Drug Abuse Treatment; Concrete Services; Crisis Intervention; Legal, Medical, Parent and Child Education; Respite; Social Support; and Therapy. Fifty-nine discrete services are also described.

The guide also contains a special section on cultural and ethnic issues and a series of papers contributed by consultants to the project that highlight many issues of interpretation and implementation of the efforts provisions. A synopsis of the research in the field and a complete bibliography are also included.

Copies of the guide, at $40.00 each, can be ordered from Northwest Resource Associates, 909 N.E. 43rd, Suite 208, Seattle, Wash. 98105. Technical assistance and consultation are also available.

The development of a case plan, preferably done jointly by the child welfare worker and the parent(s), is also an important element in the efforts requirements. The case plan must be related to the risks to the child. After a family has been identified as needing protective services, there is sometimes a tendency in child welfare to begin to address all of the family's problems rather than those that are placing the child at risk of abuse or neglect.

Active and/or reasonable efforts go beyond simply offering services to a family. The obligation of the child welfare worker is that she or he encourage and assist the parents in using a service. This involves making the service accessible by providing a convenient location, a desirable time, and transportation and child care, if necessary. The intensity of the effort and the diligence of the child welfare worker must be appropriate to the needs of the parents as they relate to the risks to the child.

These efforts must also be appropriate to the family's ethnic, racial or cultural background and delivered in a context that is comfortable and sensitive to the family. Experience in child welfare services indicates that successful assistance to families stems from, and is affected by, the extent to which the worker is able to identify cultural strengths upon which to build an appropriate case plan. Respect for cultural and ethnic differences and recognition of the potential of this diversity to enhance the worker-client relationship are vital aspects of reasonable and active efforts.

The timing of the various elements of the effort must also be considered. Because a large proportion of child abuse and neglect cases involves alcohol or drug abuse by the child's caretaker, it is usually ineffective to provide services until drug or alcohol dependency or addiction are successfully addressed first. In these cases, then, providing the necessary treatment before other interventions becomes part of the reasonable or active effort.

Another set of variables complicates the efforts discussion. Since each child welfare case is unique, efforts will, necessarily, vary depending on the specifics of the case. Different efforts would be considered active or reasonable depending on such factors as the child's age, the cultural background of the family, the capacities of the parents, the kind(s) of abuse or neglect, the strength of the extended family and the availability of other significant supporting individuals. For example, the efforts required to assist a family with a disabled or handicapped child would probably differ from those needed by a family where the child is developing normally.

Sometimes, too, efforts must be directed toward the child as well as the parent. Children who are at risk of out-of-home placement as a result of their behavior—such as violence toward themselves or others, or drug or substance dependency or addiction—should be the direct recipients of active or reasonable efforts, along with their parents.

Resource availability is also an issue. A child welfare worker may determine that a specific service option, such as a Homebuilders type of intensive in-home services, is indicated for a family to avoid an out-of-home placement. If this resource is not available in the community and its absence places the child at continued risk, the caseworker must decide whether or not to petition the court to place the child in foster care with the justification that active or reasonable efforts have been made.

It is our opinion that this action should be taken only when all other options have been exhausted. For example, intensive in-home services may be indicated as necessary. But if this resource does not exist in the community, or if there is a long waiting list, it would be both active and reasonable to secure an approximation of this service, such as crisis intervention combined with a parent aide and a homemaker. In the absence of a parent aide or homemaker, a short-term alternative might be found by drawing on a member of the parent's extended family or church. Another option would be for the caseworker to recruit volunteers to provide this kind of service. While exploring these alternatives places an additional demand on the worker's time and resources, such efforts to avoid a placement are reasonable, and certainly active.

What is enough? What is reasonable? The questions will continue to arise and are among the issues addressed in the recently published guide, *Active and Reasonable Efforts to Preserve Families: A Guide for Delivering Services in Compliance with the Indian Child Welfare Act of 1978 (P.L. 95-608) and the Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272)* (see accompanying box). Based on an extensive review of the literature on effective interventions, it contains detailed descriptions of service options that have been shown to reduce risks to children and prevent out-of-home placements.

The guide is designed to be used by a variety of professionals and volunteers concerned with the reasonable and active efforts requirements. For example, it can serve as a case planning and management tool for child welfare workers, assisting them in documenting reasonable and active efforts that they

have undertaken with a family as well as providing suggestions for alternate interventions. Juvenile and tribal court judges can document efforts made to prevent placements and determine the extent to which these efforts were reasonable and active

We expect that administrators will find the guide helpful in defining policies and procedures related to implementing the efforts provisions, as well as in evaluating programs, allocating resources and promoting the enhanced availability of intensive in-home services. The guide can also serve as a planning document to identify innovative methods of providing services to families in communities that lack resources. Finally, we expect the guide to assist foster care case reviewers in monitoring reasonable and active reunification efforts. ■

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Judicial Determination *(Continued from page 26)*

State University of New York—Albany and Research Assistant Gary Comstock. The team studied both courts and agencies, visiting sites identified as having effective approaches in implementing reasonable efforts. The "best practices" of these agencies will be used in developing manuals for agencies and courts.

Prior to these site visits, the Foster Care Project conducted a review of state laws and agency policies on preventive services and efforts to avoid unnecessary placement. Pilot studies were also conducted in Richmond, Virginia, and Wilmington and Dover, Delaware. The programs and courts chosen for the study were Santa Cruz, California; Jacksonville, Florida; Rochester, New York; Davenport and Tipton, Iowa; Portland, Oregon; and Cloquet and St. Cloud, Minnesota.

The study utilized five methods of obtaining data: compiling state and local policy, interviewing, reviewing casefiles, viewing hearings, and conducting a time study. The teams spent a week in most states, interviewing judges, agency or county attorneys, caseworkers, agency supervisors, parents' and children's attorneys, guardians ad litem, court-appointed special advocates and service providers about their experiences with reasonable efforts and the court process. In the case reviews, we looked for good documentation of efforts to provide preventive services by the caseworker and of the judge's findings. The time study measured the time spent by caseworkers at various tasks related to reasonable efforts in order to determine the amount of time that could reasonably be spent in preventing placement.

Practical Approaches to Implementing Reasonable Efforts

The agencies and courts that we studied provided some unique examples of methods to best implement the reasonable efforts requirement. Each program had special strengths, and each participant in the process—judges, administrators, supervisors, caseworkers and attorneys—could play a critical role in preventing unnecessary placement.

We found that judges who were knowledgeable concerning preventive and reunification services were better able to evaluate agency efforts. Background in child welfare—as a juvenile probation officer, for example—is extremely helpful to a judge in formulating intelligent questions, determining whether the agency had made reasonable efforts and ordering alternative service programs. Judges can also urge the agency to initiate new service programs for special groups. In Florida, the agency began a special program for adolescents in response to a judge's concern over the lack of alternatives for adolescent status offenders who have been abused.

Judicial oversight of reasonable efforts has had the strongest impact on agency practice where judges review agency efforts thoroughly and critically, not hesitating to make negative determinations of reasonable efforts in extreme cases. One judge found that making an occasional negative determination had a great impact on casework and services to keep families together, but had little impact on agency funding. The financial impact was slight because the judge made negative determinations in a very small proportion of cases and the agency was nearly always able to correct the problem and get a positive determination in a relatively short time, thus allowing the federal matching funds to resume. Interestingly, there was not a single site in our study where judges found a lack of reasonable efforts in a substantial proportion of cases. Where negative determinations were made, they were limited to situations that were viewed by judges as extreme lapses in casework and services.

In some states, judges play an

important role in the passage of state statutes mandating a judicial determination of reasonable efforts. In New York, a special amendment going beyond the federal requirement, requiring such a determination in voluntary placement cases, was prompted by judges who felt this type of judicial oversight was necessary to assure service delivery to these families. In addition, the state Permanency Planning Task Forces sponsored by the National Council of Juvenile and Family Court Judges have been instrumental in educating judges on legal issues related to reasonable efforts.

Concerted agency efforts to communicate with the juvenile court seem to be necessary in order to consistently meet the new reasonable efforts requirement. Joint meetings with agency officials and judges are helpful in establishing new procedures and guidelines for documenting efforts. Some agencies use their "court liaisons" or "court workers," who are knowledgeable about court procedure and who compile information on specific cases for court hearings, to aid in implementing the judicial determination. The court workers are charged with assuring that the judge is receiving enough information to make the determination intelligently and that the determination is actually made in every case. If these workers uncover noncompliance or systematic problems, this information is passed on to supervisors or administrators who may take it up with the court.

Many of the agencies recognize the importance of documenting preventive services in obtaining a favorable judicial determination. Some systematically include this information in the petition or court report. An extensive set of forms including information on reasonable efforts has been an integral part of the New York agency's success in implementing the requirement.

Judges who were knowledgeable concerning preventive and reunification services were better able to evaluate agency efforts.

Another fundamental element of reasonable efforts is the availability of a comprehensive array of service alternatives for families. Although this depends largely on state law and financial support, one agency was able to expand and improve services by organizing the community, bringing together public and private agencies, churches and community groups in preventing and treating child abuse. Another program was also able to provide a broad range of services by carefully defining its service needs, encouraging the creation of private service providers in the community and carefully targeting its available funds on service gaps. Relationships with outside service providers are geared to the goals of reasonable efforts, and these collaterals are expected to provide documentation of their efforts to the agency and the court.

We found that in many cases the availability of certain specialized services, such as treatment for addicted babies, is increasingly important to making reasonable efforts. Since adolescents often require a different approach than young children, some agencies have initiated special programs for this group. Many communities need service providers that focus on black and other minority families.

Agencies view homemaker services as most important and useful in many types of cases. Homemakers are used by many of the programs we studied to provide hands-on training to parents and also to evaluate the situation in the home.

Programs in smaller population areas have special problems related to the stigma that clients feel when accepting services from public agencies. When one rural program found that the state cars that workers used for home visits were observed by neighbors and therefore created embarrassment and resentment on the part of many clients, the agency shifted to unmarked cars in an effort to maintain the families' confidentiality.

We observed a number of interesting examples of flexibility in dealing with different family situations to avoid unnecessary separations of children and parents. In one case, an agency placed a child and her young adult mother with a foster family in order to provide supervision and role modeling without separating parent and child.

Agency attorneys also have an important role in implementing reasonable efforts. They can provide a necessary link between the agency and the court, informing the court of the agency's resources and constraints and informing the agency of the court's expectations. At one site, the county attorney, a former social worker, uses her expertise to prepare cases showing reasonable efforts. She also uses the reasonable efforts determination to document the agency's provision of services at later hearings. When seeking to terminate parental rights, factual findings that recount services provided and parental failure to respond prior to removal provide important evidence that agency efforts were adequate. This kind of documentation is much more effective and easy to present when

Many of the agencies recognize the importance of documenting preventive services in obtaining a favorable judicial determination.

placed in the court record.

At some sites, parents' and children's attorneys attempt to use the reasonable efforts determination to help their clients get necessary services. By being prepared to urge the judge to make a negative determination, they can sometimes convince the agency to leave the family intact and provide additional services to their clients. Legal aid programs that represent parents are also able to assure that state legislation on reasonable efforts is being applied and initiate lawsuits to enforce it. Guardians ad litem and court-appointed special advocates are also important in filling in advocacy "gaps" in some of the programs we visited. They were able to argue for additional services, and their recommendations had more influence with the judges.

Preliminary Conclusions

From the information gathered from the study, we are beginning to articulate guidelines for the judicial determination of reasonable efforts. Even though situations that require intervention and service alternatives vary on a case-by-case basis, there are some general principles that should guide judges and caseworkers.

Review of preplacement services by courts is very new and has a long way to go. More progress has been made in the review of reunification services, since many judges have already been fulfilling this role in termination of parental rights cases and thus can extend their expertise to foster care review. However, extension of these skills to preventive services is more of an innovation, and there is a need for further training of judges on the judicial determination of reasonable efforts to prevent placement. Courts which already devote a substantial amount of time and attention to child welfare cases are most able and willing to implement reasonable efforts in a meaningful way.

The judicial determination of reasonable efforts is still a relatively new area for agencies. We found that most of the agencies that had progressed the farthest in implementing the federal requirements had early policies related to the prevention of unnecessary foster care. These agencies have changed worker attitudes so that foster care is considered a last resort, and they had long recognized the need to expand service options for abused children and their families to avoid unnecessary separation of families.

Agencies appear to respect courts that closely scrutinize their efforts to avoid placement, where the judge is viewed as competent, realistic and not hostile. Agencies generally consider it a burden to be thoroughly reviewed by the judge on reasonable efforts, but where this review is done thoroughly and competently, it seems to reinforce the morale and competency of caseworkers. Accountability is a necessary element of professionalism. Skilled workers will feel vindicated by positive determinations and gain from judicial input about service expectations.

Documentation of efforts both within the agency and for the courts is also critical for successful implementation of reasonable efforts. Although uniform documentation of the reasonable efforts determination is necessary for full compliance, the use of "boilerplate" provisions in court orders raises the issue of whether the spirit of the law is being met.

The enlistment of agency counsel in pursuing the objectives of reasonable efforts is an important but underutilized aspect of implementation. Agencies should call upon their attorneys to educate judges and advocate in court on the necessity of the reasonable efforts judicial determination. Advocates for parents and children and guardians ad litem should also address these issues to increase clients' access to services.

The reasonable efforts requirement is a significant reform in the effort to shorten the length of time children spend in foster care. Preventive services need to be encouraged, because treating a family while the child is in the home is generally more effective than working with parents while the child is in placement. Earlier and more frequent court oversight of agency services leads to quicker resolution of the family's problems, or clarifies earlier the intractability of these problems. More documentation of services to the family at earlier stages of the legal proceedings will aid in another aspect of permanency planning: the termination of parental rights when problems cannot be resolved. Because of the important benefits to children in crisis, the implementation of reasonable efforts determinations needs to be a strong priority of both agencies and courts. ■

Debra Ratterman is Assistant Staff Director of the American Bar Association Foster Care Project, Washington, D.C. The contents of this article should not be construed as official policy of the American Bar Association.

Book Reviews

Working With Multiproblem Families

Lisa Kaplan (Lexington, Mass., Lexington Books, 153 pp., $15.00)

Reviewed by Marcia Allen and Wendy Deutelbaum

Lisa Kaplan has provided an important service for both family therapy and child welfare in her book, *Working with Multiproblem Families.* Most of us who are currently in the trenches promoting family-based treatment have not taken the initiative to write comprehensively on working with multiproblem families. Fortunately, Lisa Kaplan has done it for us.

At a recent conference of the American Family Therapy Association, it was noted that family therapists need to begin to address the fact that there is a large population of families in this country who need and deserve treatment but are not now receiving it. Clinical therapists must expand their concerns, get out of their consultation rooms, and revise their preconceived notions about who can and cannot change. For their part, child welfare workers need to recognize how much the family therapy field can help their agencies preserve families and prevent out-of-home placements. Both groups have had territory to maintain over the years, and the effect of this protectiveness and defensiveness has been to leave multiproblem families without adequate resources for change.

The picture looks something like this: Family therapists have a natural investment in their education, training and professional qualifications. Like all of us, they want to look successful and minimize the possibility of failure in their work. Over the years, it became easy for them to wall themselves off in clinics, establish elaborate criteria for client intake, and work only with those families most motivated to change. If family members would not or could not come to the office, they were not demonstrating "sufficient motivation." Clinical systems maintained by hourly payment rates did not allow therapists to use valuable treatment time for travel to client homes, and treatment practices and supervision techniques structured around the use of 2-way mirrors and videotape equipment further prevented outreach. Thus, a doubly pernicious system was established, one that works only with motivated clients who come to offices and that views professionals who work in clinics as the only practitioners skilled enough to work with these "most difficult" clients. It's a "Catch-22" sort of plot: The clinical system excludes the most difficult clients while maintaining that clinical therapists are the professionals best qualified to deal with them.

The child welfare system has unwittingly conspired in this stance. Like family therapists, child welfare workers want recognition for their professional accomplishments. They, too, have marked off a territory: Rather than "treatment," child welfare agencies have become experts in "case management." Although workers utilize clinical services, they tend to think, more or less covertly, that the clinicians "don't really understand" the types of clients they have to deal with. Their own expertise derives from being on the front lines with the most difficult and intransigent problems in our society: poverty, discrimination, domestic violence, abuse, neglect and juvenile delinquency. They know the frustration of dealing with these families and, lacking the skills and resources to promote change, have often adopted the clinicians' view that these families simply cannot change.

In *Working with Multiproblem Families,* Kaplan dispels this despairing myth. She lets us know in the strongest possible way that multiproblem families can and do change when the right resources are mobilized on their behalf. This is a message that both family therapists and child welfare workers desperately need to hear. To convince us of her thesis, Kaplan offers a wealth of arguments and materials. Her book ranges widely from a definition of multiproblem families, through the assessment and treatment processes, to the pragmatics of establishing agency structures that will serve these families, a "comprehensive program model," a resource directory and an extensive, annotated bibliography. With

her easy-to-read style, which avoids professional jargon, Kaplan effectively includes in her audience anyone working in the helping professions, in the social services or mental health fields, in medicine or in law. We would recommend this book to all those who are involved with multiproblem families.

If there is a flaw in this book, it is that Kaplan's examples do not keep pace with her theories. Although she takes the position that multiproblem families do change, she still avoids dealing with some of the "hard core" cases that are presented to child welfare agencies every day. Among the examples given, Kaplan refers to family members who don't close the doors to their rooms and kids who aren't doing their homework. Clearly these individuals have doors to close and kids who are in school. Few—if any—examples are included of families with abuse and neglect problems, and the "identified client" she refers to is usually the child. While child welfare caseloads do consist of families with private rooms, children in school and kids with status offense problems, in many families it is the parents whose behavior has been abusive or neglectful. It would have been helpful if Kaplan had included more examples of these families and showed how they were helped. The section of the book devoted to referral information is also problematic in that it appears to seriously limit the families who could receive services; more families might be screened out than screened in by this process.

This relatively minor criticism about the representative nature of Kaplan's examples signals, like the tip of an iceberg, what may be a more dangerous limitation to her book: it relates essentially to private agencies as the providers of services. While this is not explicitly stated, Kaplan mentions "referral information" in a way that implies that the family treatment referral comes from outside the agency. The point, once again, is that Kaplan's focus could be expanded. The only public agency listed under "Exemplary Programs" is Oregon's. Public agencies that have in-house family-based programs stand to affect more families than many of the private programs that contract with public agencies. For example, 1,804 families a year are seen in Oregon's High Impact program compared to 662 families at the Center for Family Life in Brooklyn, the largest private program listed.

From our work at the National Resource Center on Family Based Services, we know that enthusiasm for family based services is increasing. To illustrate how rapidly the field has developed since Kaplan compiled her materials, in which only one public agency is mentioned, the National Resource Center has recently published a directory describing 152 family based programs operated by public agencies.*

One last comment about this generally excellent book. Time and again, Kaplan is attentive not only to our attitudes about our clients, but to the very words we use to describe them and the reality of our work with them. She writes of hope, enhancement and growth, of family strengths, family assets and family potential. Kaplan is right: A move from the medical model that focuses on family weaknesses to an approach that focuses on family strengths involves a serious shift in semantics. After hearing all our professional lives a language of pathology, we must now learn to speak one of hope and of strengths. If we are serious about adopting a non-deficit approach to working with families, we might begin by discarding the term "multiproblem" in favor of a more positive term—like multiple need. Indeed, if we could stop labeling families altogether, both they and we would be considerably better off.

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** Annotated Directory of Selected Family Based Service Programs* (247 pp., $12.00), available from the National Resource Center on Family Based Services, School of Social Work, Oakdale Campus, N240 OH, Oakdale, Iowa 52319.

DIVORCE

The Process of Divorce: How Professionals and Couples Negotiate Settlements

Kenneth Kressel (New York, Basic Books, Inc., 349 pp., $23.95)

Reviewed by Cynthia Johnson Bell

The divorce settlement process has powerful potential to promote stability in the lives of children of divorce. Yet the stud-

ies in this book show the general failure of the divorce settlement process to foster a cooperative atmosphere in the post-divorce family. This failure has serious implications for children of divorce since they show increased fighting, acting out of separation anxieties and lessened parental controls.

This important book gives guidance to professionals for constructive handling of divorce conflict that can have an impact upon the lives of children. Kenneth Kressel, a social psychologist, explores the ways in which social workers, mental health professionals, lawyers and divorcing parents shape the divorce settlement process. *Process of Divorce* stands out from others in the field by its analysis of mediation cases and its foundation in original and previously published empirical research with attorneys and marital and family therapists.

The book focuses on divorce settlement negotiations on such matters as custody, visitation, child support and the division of marital assets. Kressel's conclusions challenge conventional wisdom on divorce negotiations. A primary finding of this volume is to dispute the popular belief of a destructive influence by lawyers and the adversary legal system on divorce negotiations. Another surprising finding is that divorcing parents, rather than attorneys, do most of their own divorce settlement negotiations. In fact, rather than escalate conflict, the divorce attorney is found to be a benign influence.

An equally stunning finding is the powerful, but indirect, influence of social workers, psychologists and psychiatrists on settlement negotiations through treatment and advice in divorce therapy. Since divorced persons are more likely than any other group to seek psychotherapy, "the potential for containing and re-directing conflict in this group must be considered correspondingly large," Kressel notes. The trend of mental health workers becoming central in settlement negotiations through the emerging field of divorce mediation is traced. An overwhelming majority of mediators in the private sector are mental health professionals, primarily social workers (42 percent). Kressel goes against a national course in concluding that divorce mediation is not innately superior to any other method of conflict resolution, having assets and liabilities.

Protection of children in divorce settlement negotiations is a central theme throughout this work. Public sector mediators are found to be restricted to resolution of custody and visitation disputes. The author notes that this focus "reflects both the court's formal role as ultimate guardian of the children's interests and the much greater willingness of bench and bar to acknowledge the limits of their expertise in matters affecting children."

Nonetheless, he concludes from existing research that mediation is still "of uncertain value as a tool for helping children." Since there is a lack of consensus on what constitutes a fair divorce settlement, Kressel sets forth criteria designed to protect the best interests of children of divorce.

Chapters addressing the roles, activities and problems of family law attorneys, divorce therapists and divorce mediators bring a wealth of information and innovative solutions. Role stresses in divorce attorneys result in two different adjustments, according to the author. Divorce attorneys can be classified as "counselors" and as "advocates," with the former more inclined to cooperative negotiated settlement. A major finding is that the divorce mediator is subject to the greatest role stress, although the mediator shares many of the same stresses as the divorce attorney. Practical help is given to reduce these stresses in roles.

Other valuable contributions for professionals are an examination of the relationship between therapy and mediation; discussion of the obstacles to constructive negotiations; and specific suggestions on how research on negotiation can be improved. The author calls for research on the attorney-client relationship by direct observation as a further means of understanding divorce settlement process.

This stimulating book reaches conclusions opposite to those in the contemporaneous Gardner volume, *Child Custody Litigation,* and so should promote dialogue among professionals. Most controversial is Kressel's finding that no one cause accounts for the poor outcomes in divorce settlement. He raises the complexity of the settlement process and gives a useful picture of the interplay of many factors.

One limitation of the book is that the author's conclusions on divorce therapy are partially based only on a study conducted in the private sector and hence may not be generalized to the growing public services in divorce therapy, especially court-affiliated therapy. Another limitation is that some of the interviews were conducted in the mid-1970s prior to the rapid growth in mediation and joint custody. Yet the author is cognizant of this fact, and carefully

analyzed current research on divorce mediation and joint custody to provide balance.

The book's greatest contribution stems from its ability to empower the triad of divorce attorney, divorce therapist and divorce mediator to work together more constructively and to deal realistically with the inherent limitations and role stresses in their respective work. Another contribution is the recognition that divorcing parents retain decision making in settlement negotiations and therefore have it within their power to be full partners in the negotiation process and to own their agreements. This volume gives hope and direction to the professional that constructive divorce settlements can be achieved on behalf of families and children of divorce.

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Utah *(Continued from page 25)*

newly acquired skills. This was the case with the Stevens family.

However, the support of the probation department—which continued to monitor the boys' behavior and to reinforce the parents' limit-setting efforts—was welcomed by the family. The boys' school performance improved dramatically: Mark's attendance jumped to 90 percent and he began earning A's and B's. This improvement in behavior and academic performance continued throughout the remainder of the school year with the support of the probation department.

Characteristics of Participants

In 1985, 192 children and youths—involving a total of 140 families—received Family Preservation Services. By the end of 1985, 168 children and youths were no longer receiving project services. Each family received an average of 34 hours of direct services and an additional 19 hours of indirect (collateral and consultation, for example) services. The average caseload was six cases per worker and the average length of service was 60 days.

The majority of clients served by the project are multi-problem families who tend to be chronic consumers of public social and mental health services, and repeatedly come to the attention of child protective service agencies and juvenile court. Some 75 percent have had prior contact with social service agencies, and 33 percent of the target children have previously been in some type of substitute care. Because of the chronic and severe problems evident in these families, mental health and social service agencies have not traditionally been equipped to serve this population.

Of the 192 children and youths receiving services, 55 percent were male and 74 percent were over 10 years old. In the last 10 years, there has been a shift in the age of children placed in foster care in Utah. During the 1970s, the majority of children placed were under 10 years of age. In 1985, only a quarter of the children placed were under age 10; 53 percent were between the ages of 11 and 15.

The most common family structure was a single parent family (36 percent), followed by two natural parent families (30 percent). Blended families accounted for 28 percent and adoptive families for five percent. Thirty-four percent of the families had a gross annual income of less than $10,000, and 21 percent of these families received AFDC. Nineteen percent had an income of over $25,000.

More than half of the families—58 percent—had three or four children and almost one quarter (23 percent) had large families of five or more children (see Table I).

In 84 percent of the families, there was a parent with at least a high school diploma. In nine percent of the families, there was a parent with a college degree (see Table II).

In looking for factors that contributed to the child being in imminent danger of removal from the home, we found that runaway and ungovernable behavior, truancy and child substance abuse were most frequently cited (see Table III).

Project Results

Project outcomes during the first year of operation have been positive and beneficial in several ways. Primarily, the Family Preservation Projects have been able to maintain 85 percent of the children served in their own homes (see Table IV). An additional five percent were living with relatives and friends.

These results lead us to believe that we are on the right track. We believe that through intensive Family Preservation Services we are having an impact on the upward pressure for foster care and out-of-home placements. In addition, clients consistently rate project services as

Table I. Family Size

Number of Children in Family

	Number	Percent
1	6	4
2	21	15
3	42	30
4	39	28
5	18	13
6 or more	14	10
Total	140	100

more helpful to their family than previous counseling experiences, and they believe that having the child remain in the home is best for both child and family.

If success were measured only by the number of children who were able to remain safely with their families, you could say that Utah's Family Preservation Projects have been very successful. Of the 168 children and youths who had completed the program by December 30, 1985, only 17 were placed in subsidized out-of-home care. Eight of the 17 were in temporary shelter care. It is our hope and expectation that the services provided to families will also reduce the likelihood that other children in the family will be referred for placement in the future. Utah is moving ahead to expand the Family Preservation concept to all service areas in the state through its statewide policies and training. ■

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Table II. Parent Education

Highest Grade Completed By Either Parent

	Number	Percent
Less than High School	23	16
High School	71	51
High School +	34	24
College Degree	12	9
Total	140	100

Table III. Contributing Factors

Child/Family Problem	Percent
Runaway/Ungovernable	65
Child substance abuse	42
Truancy	40
Delinquency	36
Child physical aggression	29
Parent physical aggression	27
Child sexual abuse victim	21
Learning disability	21
Child chronic mental health problem	17
Parent substance abuse	13
Child suicide potential	12
Parent sexual abuse victim	10

Table IV. Child Status After Treatment

	Number	Percent
At home	143	85
Shelter/emergency foster care	8	4
Friends	3	2
Relatives	5	3
Foster care	1	1
Group care	3	2
Treatment facility	5	3
State hospital	0	0
Total	168	100

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